

DEPARTMENTS OF LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION, AND RELATED AGENCIES
APPROPRIATIONS FOR 2009

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

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CHERYL SMITH, SUE QUANTIUS, NICOLE KUNKO,
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Subcommittee Staff

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Printed for the use of the Committee on Appropriations

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**DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RE-
LATED AGENCIES APPROPRIATIONS FOR
2009**

THURSDAY, MARCH 6, 2008.

**BUDGET REQUEST FOR THE DEPARTMENT OF LABOR
FOR 2009**

WITNESS

HON. ELAINE L. CHAO, SECRETARY, U.S. DEPARTMENT OF LABOR

CHAIRMAN'S WELCOMING REMARKS

Mr. OBEY. Well, good morning, Madam Secretary. Today, the Committee will review the budget request for the Department of Labor for the coming fiscal year.

Madam Secretary, let me say something before we begin. I think you are a very nice person and I respect the job you try to do, but I have very basic disagreements with some of the policies that you are pursuing. And I apologize ahead of time, but I am going to take a little more time than I normally do on opening a hearing to explain what my concerns are.

First, I am troubled by a recent press article concerning some remarks attributed to you. According to those articles, in a February 7th address to the Conservative Political Action Conference you cited several milestones for your tenure as Secretary of Labor. One of those milestones was reportedly that "the Department's fiscal year 2009 budget is nearly 15 percent less than 10 years ago." I, frankly, do not see that as an accomplishment, considering what has occurred over the past few years in this economy.

There are 7.6 million unemployed Americans today, 26 percent more than was the case seven years ago. The number of people who have been unemployed for more than 27 weeks, long-term unemployed is now double the January 2000 level. That includes several members of my family, and I think many members of Congress can say the same thing.

Under the last seven years we have lost 3.2 million manufacturing jobs. The service sector, which amounts to two-thirds of the U.S. economy, has contracted in January, for the first time in five years. New unemployment numbers are going to be released tomorrow. Nobody expects the news to be any better.

Despite those economic conditions, which appear to be worsening—and those conditions, I would suggest, should tell us that we ought to be making greater investments to assist the unem-

ployed and those at risk of losing their jobs—your budget cuts funding for programs run by the Department by \$1.2 billion, or 10 percent, below fiscal year 2008.

In real terms, after accounting for inflation and population growth, which is the only way to measure the per capita impact on people, your budget is \$5.3 billion, or 33 percent, below its 2001 level.

Over the past several weeks, this Subcommittee has been holding a number of hearings to try to achieve a clear understanding of the context in which these policy decisions are being made. One of the witnesses was Harold Meyerson, and I would like to read what he said. He said, “The benefits, pensions, and rising annual income that were the common, though by no means universal, experience of American workers a generation ago are now a thing of the past to all but the talented or, more precisely, the fortunate tenth. We are no longer a Nation of good jobs.”

Jared Bernstein, another economist, told us that working families are working harder and smarter, but real incomes are down and poverty is up.

Another economist, Harry Holzer, said the following: “The very low earnings and employment of millions of Americans generate high poverty rates and impose huge costs on the U.S. economy.

Those presentations, I think, helped us to understand that the cost to society of not making these investments can be very, very high, and I would like to examine some of the consequences of your budget.

STATE EMPLOYMENT SERVICES FUNDING

Under this Administration, funding for the State Employment Service has been cut by \$93 million, or 9 percent, at the same time that the working age population has grown by 9 percent and unemployment has climbed by nearly 17 percent. Your fiscal year 2009 budget proposes to eliminate Federal support.

The Employment Service helps 13 million people by matching people who need jobs with employers who have available openings. The budgetary cost of the Employment Service may be \$703 million a year, but the cost of not providing those services could be much higher in terms of lost wages to workers.

TRAINING PROGRAMS FUNDING

Your budget makes more than \$500 million in cuts in job training programs, including \$173 million in cuts to youth training programs. When we consider the reduced lifetime earnings of a high school dropout, \$187,000 per dropout, or I should say when we look at the additional costs to Government in social welfare benefits for people who drop out and the cost in terms of medical services, and in many cases incarceration, that \$173 million cut to youth programs could wind up being very costly indeed over the next 20 years.

Your budget repeats last year’s proposal to slash part-time minimum wage community service job grants for 34,000 low-income senior citizens. That proposal would cut the program by \$172 million, or 33 percent, below the fiscal year 2008 level.

It seems to me, Madam Secretary, that your Department is the agency that, above all others, has an obligation to try to reduce the gap in human potential that we have in this society between those who were born on third base and those who were not. We have a labor market that places a premium on skills and, yet, this budget squeezes programs that will help workers to develop those skills and makes inevitable the growth of the gap between the most well-off people in this society and other people who are struggling on the edges, trying to grab a piece of American hopes and dreams.

So I am extremely disquieted by your agency's budget and I am afraid that the tenor of my questions will reflect that this morning. Do not take it personally. You have got your job to do, but we have got our job to do too, and when we see priorities that I think are as misbegotten as these, I think we have got an obligation to address them.

Mr. OBEY. Let me turn to Mr. Walsh for his comments before I ask you to make your statement.

RANKING MEMBER'S WELCOMING REMARKS

Mr. WALSH. Thank you, Mr. Chairman.

Madam Secretary, welcome. Good to have you back.

Unless I am mistaken, you hold the distinction of being the longest serving member of the President's cabinet. Congratulations to you and thank you for your service; confirmed just after the inauguration in 2001, so we thank you for that long and distinguished service.

I said to you last year, I believe, it is a great time to be Secretary. I am not sure I can offer the same this year because of the downturn in the economy. But, you know, these economies are cyclical in nature and sometimes Federal policies impact on that and sometimes they do not.

Even before the Budget Committee marks up the budget resolution, even before we hear testimony on the fiscal year 2009 request, already there are threats of vetoes and continuing resolutions. I fear the prospects of what will be delivered by this Congress are seemingly a muddle at this point.

From my observation, Mr. Chairman, this bill has been subjected to political maneuvering from both parties for too long; from both parties, in both bodies, and at both ends of Pennsylvania Avenue.

As the Nation endures another year of electoral politics and ultimately a transition to a new administration and new executive leadership, it is important to maintain some degree of institutional integrity across the Federal Government, and I believe the Congress can still do its part by providing funding for the continuity of these critical Labor programs.

For all of its efforts in promoting employment opportunities and training services, the Department of Labor is often graded harshly on its monthly unemployment rate. Yet, according to statistics—and we have heard some statistics already and we will hear more—the average unemployment rate has steadily declined over multiple administrations, from a high of almost 10 percent back in the Carter years to its current rate of 4.9 percent today. Millions and millions of more Americans working today than then. So it is indeed good news.

Speaking of statistics, the Chairman talked a little bit about this year, this current unemployment rate versus 2001. At one point in 2001, before the technology boom had burst, unemployment was fairly low. Within a year it increased by almost 1 percent. Part of that was because the technology boom burst and part of that was because of the attack on the United States on September 11th. But much like the recent housing market bubble burst, that bubble burst also, and it would be hard to lay blame on any individual for either of those; it was a sort of collective mess that we got ourselves into.

But the unemployment rate, which hit about 5 percent in September of 2001, continued to go up after September 11, into 2002, 2003, to about 6 percent, but it remained lower than the unemployment rate in the mid-1990s; and since that time it has been on a steady decline, ending in January of 2008 at 4.9 percent.

Mr. Chairman, this request proposes \$10,500,000,000 in discretionary authority for the Department of Labor, including \$2,800,000,000 for high-quality job training and employment services; \$238,000,000 for veterans transitioning to civilian life, many having served multiple tours of duty in Iraq and Afghanistan; and \$2,700,000,000 to support unemployment insurance.

It also proposes some things that will have to be debated. For example, a 14 percent reduction in WIA programs and the elimination of the Employee Services Grant to States, a reduction of \$700,000,000 that was ostensibly taken to avoid a duplication of services. More realistically, it was taken to meet an arbitrary number given by OMB.

This request is not perfect, but we need to recognize the historical efficacy of these programs and services in maintaining consistently low unemployment, as well as our competitive position in the global economy.

Mr. Chairman, I look forward to working together with you on this request, on this budget, and with the Secretary, and I yield back.

Mr. OBEY. Thank you, Mr. Walsh.

Just one point before we begin. I think if you examine my opening comments, I specifically avoided trying to attach any blame to any specific administration for unemployment rates. Unemployment rates result from a variety of causes. I think rather than getting into a question of who shot John on unemployment, I think the most important issue is simply what we ought to be doing about the problem.

Please proceed with whatever comments you would like to make. We will put your entire statement in the record. If you could summarize it in about 10 minutes, I would appreciate it.

Secretary CHAO. Yes.

SECRETARY'S OPENING STATEMENT

I have a statement for the record that I would appreciate if we can submit for the record, and I will just briefly summarize.

Mr. Chairman, Ranking Member Walsh, and members of the Committee, I appreciate—

Mr. OBEY. Could you pull the mic a little closer, please?

Secretary CHAO. Mr. Chairman, Congressman Walsh, members of the Subcommittee, we appreciate the opportunity to present the Administration's budget for fiscal year 2009 for the Department of Labor. The total request for the Department is \$53,100,000,000, \$10,500,000,000 is for discretionary spending.

The Department's fiscal year 2009 budget focuses on five overall priorities: protecting workers' health and safety; protecting workers' pay, benefits, long-term security, pensions; modernizing the temporary foreign labor certification programs; securing the employment rights of America's veterans; and increasing the competitiveness of America's workforce, of which you and I are both concerned.

In fiscal year 2009, \$1,400,000,000 is requested for the Department's worker protection programs. This request includes \$332,000,000 for Mine Safety and Health Administration and an FTE of 2,361. We are increasing funding for enforcement. And while there is a slight reduction over the fiscal year 2008 enacted level, this is due to the fact that last year's fiscal year budget had a one-time expense, including the overtime and travel expenses associated with training new inspectors. This current request enables MSHA to continue implementing the Historic Mine Act and maintains our strong commitment to Mine Safety and Health.

This request also includes \$7,400,000 specifically targeted to support and train an additional 55 Mine Safety Enforcement personnel, which enable MSHA to complete 100 percent of the mandated mine inspections. This is in addition to the 273 enforcement personnel that were hired last year, last fiscal year. So the result is a new increase of 177 Mine Safety Enforcement personnel as of January 31st of this year, which brings the total number of coal enforcement personnel to its highest levels since 1994.

The budget will support MSHA's efforts to finalize rules on Belt Air and Mine Refuge Chambers, and to vigorously enforce increased monetary penalties.

The fiscal year 2009 budget request also includes \$501,700,000 and 2,173 FTEs for OSHA. This is a 3 percent increase over the enacted level last year.

The fiscal year 2009 budget request before this Committee for the Employment Standards Administration is for \$468,700,000 and 3,190 FTEs. The request for ESA includes \$193,100,000 and 1,283 FTEs for the Wage and Hour Division, and the request for Wage and Hour includes \$5,100,000 to hire additional 75 inspectors.

ESA also requests \$89,000,000 and 585 FTEs for the Office of Federal Contract Compliance Programs (OFCCP) to protect workers from discrimination by Federal contractors and another \$110,200,000 and 872 FTEs are requested for the Office of Worker's Compensation Program.

Let me note that the Department of Labor recently passed the \$3,500,000,000 mark in compensation to Energy Employees Occupational Illness Compensation Program beneficiaries and initial decisions have been made in all of the 22,000 Part E cases that were transferred to the Department of Labor from the Department of Energy in 2004.

The ESA request also includes \$58,300,000 and 369 FTEs for the Office of Labor Management Standards. This is the same amount of FTEs requested in fiscal year 2008.

For the Employee Benefit Security Administration, the fiscal year 2009 request is \$147,900,000, an increase of over 6 percent over the enacted level, and 867 FTEs.

The Department is also committed to providing returning veterans with the support needed to make the transition back to the non-military workforce a smooth and successful one. So, for VETS, the fiscal year 2009 budget is \$238,400,000 and 234 FTEs, and this is a 5 percent increase over the fiscal year 2008 enacted level. This will help vets maximize employment opportunities for veterans and protect their employment and re-employment rights.

As you have alluded to, the United States is transitioning to a knowledge-based economy. New jobs are being created. In fact, 8.5 million new jobs have been created since August of 2003. The majority of these new jobs require higher skills, more education, and, by definition, they are better paying jobs. Our Country's worker training programs need to keep pace with these developments and ensure that workers have the relevant skills that they need to remain competitive and succeed in the new economy.

It is noteworthy that each year States have carried forward over \$1,200,000,000 to \$1,700,000,000 in unspent Workforce Investment Act funds. Despite the legal authority to spend funds over three years, we believe that there is an urgent need for more worker training now.

One way to make more effective the delivery of services to workers in need of training and retraining is the Administration's proposal for career advancement accounts. Career Advancement Accounts would triple the number of workers that would be able to be trained via the workforce investment system. It would also ensure that workers receive relevant training that would actually enable them to get a real job.

Too much of the funding these days is tied up in duplicative infrastructure, and reform is urgently needed to create a more effective training system that would truly meet the needs of our Nation's workers and help our Nation remain competitive in a world-wide economy. The Administration looks forward to working with Congress to update and improve the Workforce Investment Act this year.

Mr. Chairman, the mission of the Labor Department is indeed to create hope and opportunity, and the President's fiscal year 2009 budget provides the resources to accomplish this by promoting and protecting the health, safety, wages, and retirement security of America's workers. It also allows us to build on record-setting results the Department has accomplished for workers over the past seven years, and we also need to ensure that workers are indeed trained effectively and that they are able to compete in accessing real jobs that are occurring and being developed in the economy.

Thank you.

[The information follows:]

**STATEMENT OF ELAINE L. CHAO
SECRETARY OF LABOR
BEFORE THE
SUBCOMMITTEE ON LABOR,
HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES**

March 6, 2008

Good morning Mr. Chairman, Ranking Member Walsh, distinguished Members of the Subcommittee, ladies and gentlemen. Thank you for the opportunity to appear before you today to present the Fiscal Year 2009 Budget for the Department of Labor.

The total request for the Department in FY 2009 is \$53.1 billion and 16,848 FTE, of which \$13.0 billion is before the Committee. Of that amount, \$10.5 billion is requested for discretionary budget authority. Our Budget request will allow us to build on the accomplishments achieved in recent years and enable the Department to meet its critical priorities for FY 2009, while helping to achieve the President's deficit reduction goals by reforming programs and reducing or eliminating ineffective or duplicative activities.

NOTABLE ACCOMPLISHMENTS

Over the past seven years, the Department's agencies that protect workers' health, safety, benefits, pay, and union member rights have achieved record-setting results for America's workers and their families. For example:

- Since 2001, the Wage and Hour Division has increased by 67 percent the back wages recovered for workers. In 2007 alone, a record \$220.6 million was recovered for workers, including many vulnerable workers in low-wage industries, who did not receive the wages they were due.
- Between 2001 and 2007, the Employee Benefits Security Administration, which has oversight over nearly every private pension plan in America, closed over 28,000 civil cases and over 1,200 criminal cases; recovered or protected over \$10 billion for plans and participants; and, working with the Department of Justice and state and local prosecutors, obtained indictments against more than 800 individuals for crimes against plans and participants.
- Since 2001, the workplace fatality and serious injury and illness rates have fallen to record lows. Since 2002, the overall injury and illness rate has declined by 17 percent. And since 2001, the worker fatality rate has dropped by 9 percent.

Perhaps most notable is the reduction in the fatality rate among Hispanic workers, which has declined by 22 percent since 2001.

- Since 2001, the Department's Office of Federal Contract Compliance Programs has posted record results in enforcing equal opportunity rights for employees of Federal contractors, with an increase in financial recoveries of 78 percent between 2001 and 2007. Our efforts to ensure that Federal contractors achieve equal opportunity workplaces resulted in a 245 percent increase from FY 2001 in the number of Americans recovering back pay and benefits.
- Since 2001, we have rebuilt the Department's Office of Labor Management Standards' capability to enforce the laws that require union transparency and protect union democracy. As a result, since 2001, the number of financial compliance audits has risen by 226 percent, and the number of convictions has increased by 16 percent. In FY 2007, court-ordered restitution amounted to almost \$32.2 million.
- We have implemented a number of new programs to assist America's veterans. The Department launched the national *HireVets First* campaign designed to help employers tap this pool of talent as our servicemen and women transition to civilian life. In 2004, the Department created *REALifelines*, a comprehensive new program to provide individualized job training, counseling, and reemployment services to each and every service member seriously injured or wounded in the War on Terrorism.

FY 2009 PRIORITIES

The Department's FY 2009 Budget seeks to build on the success of previous years. The Budget features five critical priorities: protecting workers' safety and health; protecting workers' pay, benefits, pensions, and union member rights; modernizing the temporary foreign labor certification programs; providing additional resources and services for our nation's veterans and transitioning service members; and increasing the competitiveness of America's workforce. In FY 2009, the Department will continue to pursue regulatory reforms and strengthening policies that encourage growth, job creation, and opportunity.

PROTECTING WORKERS' SAFETY AND HEALTH

The 2009 Budget includes \$1.5 billion in discretionary funds for DOL's worker protection activities. Within this funding level, \$833.7 million is requested to enable the Department to continue to pursue its record-setting protection of workers' safety and health.

Mine Safety and Health Administration (MSHA)

The FY 2009 Budget request for MSHA is \$332.1 million and 2,361 FTE. The request will allow MSHA to continue implementing the historic Mine Improvement and New Emergency Response (MINER) Act, the most sweeping mine safety legislation in 30 years. The request includes \$7.4 million specifically targeted to support and train an additional 55 mine safety enforcement personnel. These additional personnel, in addition to the 273 enforcement personnel hired in FYs 2006-2007 (and maintained in FY 2008), will enable MSHA to complete 100 percent of mandated mine inspections in both coal and metal and nonmetal mines for the first time in the 39-year history of the agency. The 2009 Budget will also support MSHA's work to finalize rules on belt air and mine refuge alternatives and implement stronger civil penalties, in accordance with the final rules published in FY 2007 and FY 2008.

Occupational Safety and Health Administration (OSHA)

The FY 2009 Budget request for OSHA is \$501.7 million and 2,173 FTE. The request provides resources to support 87,200 Federal and State safety and health inspections.

The request reflects an increase of \$15.7 million and 47 FTE above FY 2008, which includes an increase of \$11.4 million to support enforcement programs and \$5.2 million to provide compliance assistance to employers and employees, especially small businesses. The budget supports OSHA's balanced approach to worker safety and health which includes aggressive enforcement, cooperative programs, outreach, education, and compliance assistance.

PROTECTING WORKERS' PAY, BENEFITS, AND UNION DUES

In FY 2009, the Department will also continue its high priority programs to protect workers' pay, benefits and union dues.

Employment Standards Administration

The Department's Employment Standards Administration (ESA) is DOL's largest agency, which administers and enforces a variety of laws designed to enhance the welfare and protect the rights of American workers. The FY 2009 Budget request includes discretionary resources for ESA administrative expenses of \$468.7 million and 3,190 FTE, and a proposal to cancel \$30 million in H-1B fund balances.

Wage and Hour Division

The Wage and Hour Division is responsible for the administration and enforcement of a wide range of worker protection laws, including the Fair Labor Standards Act, Family and Medical Leave Act, Migrant and Seasonal Agricultural Worker Protection Act, worker protections provided in several temporary non-immigrant visa programs, and prevailing wage

requirements of the Davis-Bacon Act and the Service Contract Act. These laws collectively cover virtually all private sector workers, as well as state and local government employees.

The FY 2009 Budget request for the Wage and Hour Division totals \$193.1 million and 1,283 FTE, which excludes \$31 million in estimated fee revenue from DOL's portion of the H-1B visa fraud prevention fee authorized by the 2004 H-1B Visa Reform Act. Given the strict statutory limits on the use of these funds, DOL has only been able to spend around \$6 million in any single year. Therefore, the FY 2009 Budget cancels \$30 million of the H-1B fund balances and proposes amendments to the Immigration and Nationality Act to permit a more effective use of the fraud prevention fees collected under this provision in future years.

The FY 2009 Budget also includes \$5.1 million to hire an additional 75 Wage and Hour enforcement staff to target resources on industries and workplaces that employ low-wage, immigrant workers, as well as \$962,500 for 7 legal enforcement support FTE for the Office of the Solicitor.

Office of Federal Contract Compliance

The FY 2009 Budget request for the Office of Federal Contract Compliance Programs (OFCCP) totals \$89.0 million and 585 FTE. OFCCP is responsible for ensuring equal employment opportunity and non-discrimination in employment for businesses contracting with the Federal government. OFCCP carries out this mandate by conducting compliance evaluations to identify instances of systemic discrimination in the workplace, taking appropriate enforcement action, and providing relevant and effective compliance assistance programs. The FY 2009 Budget request for OFCCP includes \$2.0 million to launch the design phase of the Federal Contractor Compliance System, a new case management system to improve the effectiveness and efficiency of OFCCP's compliance and enforcement strategies. It will replace the existing OFCCP Information System, which was developed more than 20 years ago and is functionally inadequate to meet current program needs.

Office of Workers' Compensation Programs

The FY 2009 discretionary Budget request for administration of the Office of Workers' Compensation Programs (OWCP) totals \$110.2 million and 872 FTE to support the Federal Employees' Compensation Act (FECA) (\$96.2 million) and the Longshore and Harbor Workers' Compensation program (\$14.1 million). The FY 2009 budget for the Longshore program includes \$500,000 for addressing workers' compensation claims submitted under the Defense Base Act for civilian workers in Iraq and Afghanistan.

The OWCP budget includes mandatory funding totaling \$108.2 million and 598 FTE for the Department's role in administering the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). EEOICPA provides compensation and medical benefits to employees or survivors of employees of the Department of Energy and certain of its contractors and subcontractors, who suffer from a radiation-related cancer, beryllium-related disease, chronic silicosis or other covered illness as a result of work at covered Department of

Energy or DOE contractor facilities. The 2009 Budget requests that resources for the EEOICPA program activities carried out by the National Institute for Occupational Safety be requested directly in the Department of Health and Human Services budget. This funding request will enhance congressional oversight, while improving the financial management and transparency of EEOICPA's dose reconstruction and Special Exposure Cohort program.

Lastly, OWCP's FY 2009 Budget includes \$37 million in mandatory funding and 195 FTE for its administration of Parts B and C of the Black Lung Benefits Act, and \$52.7 million and 127 FTE in FECA Fair Share administrative funding.

The 2009 Budget includes two legislative proposals affecting OWCP programs that play a critical role in protecting workers' economic security, by providing monetary and medical benefits to Federal employees and coal miners whose ability to work has been diminished by an occupational injury or illness. The first re-proposes reforms to FECA to update its benefit structure, adopt best practices of State workers' compensation systems, and strengthen return-to-work incentives. This proposal is expected to generate government-wide savings of \$377 million over ten years. The second is a proposal to restructure, and eventually retire, the mounting debt of the Black Lung Disability Trust Fund—a debt that now stands at \$10 billion.

Office of Labor-Management Standards

The FY 2009 Budget request for the Office of Labor-Management Standards (OLMS) totals \$58.3 million and 369 FTE. OLMS enforces provisions of Federal law that establish standards for union democracy and financial integrity. OLMS conducts investigative audits and criminal investigations, primarily for embezzlement; conducts civil investigations of union officer elections and supervises remedial elections where required; administers statutory union financial reporting requirements; and provides for public disclosure of filed reports. OLMS also administers employee protective provisions created under federal transit legislation. The resources requested will allow OLMS to continue to further the goals of financial integrity, union democracy, and transparency.

Employee Benefits Security Administration

The Department's Employee Benefits Security Administration (EBSA) protects the integrity of pensions, health plans, and other employee benefit plans holding some \$5.6 trillion in assets for more than 150 million Americans. The FY 2009 Budget request for EBSA is \$147.9 million and 867 FTE. The request will maintain the strong enforcement record of recent years, and support oversight of pension and health care plans and other employee benefits. Also in FY 2009, EBSA will transition to a streamlined, entirely electronic filing system for the Form 5500 Annual Report which is filed by approximately one million employee benefit plans. These reports provide essential information on pension and other benefit plans' financial condition, investments, and operations. The move to electronic filing will substantially reduce processing times for the Form 5500 and improve the reliability of the data reported on the form. By making data on the funding of pension and other benefit plans more

transparent and accessible, this new system will support the President's efforts to strengthen retirement security for the nation's workers and retirees.

Pension Benefit Guaranty Corporation

The FY 2009 request for the Pension Benefit Guaranty Corporation's (PBGC) administrative expenses is \$444.7 million. The PBGC is now responsible for paying the benefits of 1.3 million workers and retirees. While the Pension Protection Act of 2006 made significant structural changes to the retirement system, the PBGC is still not solvent on a long-term basis. Although PBGC will be able to pay benefits for some years to come, it is projected to be unable to meet its long-term obligations under current law. Further reforms are needed to address the \$14 billion gap between PBGC's liabilities and its assets. If there is not enough money in the system to cover worker benefits, taxpayers are at risk for having to cover the shortfall. The FY 2009 Budget proposes to give PBGC's Board the authority to adjust premiums to produce the revenue necessary to meet expected future claims and retire PBGC's deficit over ten years. Proposed premium reforms will improve PBGC's financial condition and safeguard the future benefits of American workers and retirees.

INCREASING THE COMPETITIVENESS OF AMERICA'S WORKFORCE

Reforming the Workforce Investment System

The FY 2009 Budget request for the Department's Employment and Training Administration (ETA) is \$6.3 billion in discretionary funds and 1,148 FTE, which includes the 152 FTE associated with the legislative proposals for application fees in the permanent and temporary labor certification programs. Through innovative reforms, the Budget request for ETA will allow the Department to increase the competitiveness of the American workforce in a knowledge-based economy.

The United States competes in a global economy that is far different from the international markets of the past. In the future, as in the past, our long-term economic growth will also be enhanced by supporting international trade, by opening world markets to U.S. goods and services and by keeping our markets open. Congress can help create jobs and economic opportunity by passing the pending Free Trade Agreements with Colombia, Panama and South Korea. As our nation's economy and businesses transform to meet the challenges of the 21st century, so too must the government systems and structures that support our economic growth and job creation.

It is in this context that the President has sought to transform worker training programs into a demand-driven system that prepares workers for jobs in growth sectors of the economy. The workforce investment system should recognize and strengthen workers' ownership of their careers, and provide more flexible resources and services designed to meet their changing needs.

American workers will need higher levels of education and skills than at any time in our history, as evidenced by the fact that almost 90 percent of new jobs in high-growth, high-wage occupations are expected to be filled by workers with at least some post-secondary education. However, the current workforce investment system does not provide the necessary education and training opportunities for workers. Too much money is spent on competing bureaucracies, overhead costs, and unnecessary infrastructure, and not enough on meaningful skills training that leads to employment opportunities and advancement for workers.

To increase the quality of training offered, as well as the number of workers trained, the Department proposes legislative reforms to consolidate funds for the following programs into a single funding stream:

- Workforce Investment Act (WIA) Adult Program;
- WIA Dislocated Worker Program;
- WIA Youth Program; and
- Employment Service programs (including Employment Service formula grants, labor market information grants, and grants for administration of the Work Opportunity Tax Credit).

States would use these funds primarily to provide Career Advancement Accounts (CAAs) to individuals who need employment assistance. CAAs are self-directed accounts of up to \$3,000, an amount sufficient to finance approximately one year's study at a community college. The accounts could be renewed for one additional year, for a total two-year account amount of up to \$6,000 per worker. CAAs would be used to pay for expenses directly related to education and training. The accounts would be available to both adults and out-of-school youth entering the workforce or transitioning between jobs, and incumbent workers in need of new skills to remain employed. The funds would also be used by states to provide basic employment services such as career assessment, workforce information, and job search assistance to job seekers. By removing bureaucratic restrictions that can prevent workers from being trained, increasing the flexibility of state and local officials to shift funding to where it is most needed, and requiring the majority of dollars in the system to be spent on training, these reforms will significantly increase the number of individuals who receive job training and attain new and higher-level job skills.

Community-Based Job Training Initiative

The FY 2009 Budget provides \$125 million for the fifth year of grants under the President's Community-Based Job Training Initiative. This competitive grant program leverages the expertise of America's community colleges and takes advantage of the strong natural links between community colleges, local labor markets and employers to train workers for jobs in high-demand industries. In October 2005, the Department awarded the first grants totaling \$125 million to 70 community colleges in 40 States. A second competition for Community-Based Job Training Grants was held in the summer of 2006, and in December 2006, the Department awarded \$125 million in grants to 72 entities in 34 states. These grants will be

used to increase the capacity of community colleges to provide training in local high growth, high demand industries and train new and experienced workers for jobs in these industries. The Department is currently conducting a third grant competition for \$125 million and awards are anticipated during the first half of 2008. The Administration strongly supports providing standalone funding for this program, rather than redirecting funds from the National Reserve, which should be preserved to allow the Department to respond to emergency and unanticipated situations.

Foreign Labor Certification

The FY 2009 Budget builds on our successes in reforming the Foreign Labor Certification programs. The Department has eliminated the backlog in the Permanent program, which peaked at 363,000 applications in 2005. In the FY 2009 budget, the Department is requesting \$78 million for the foreign labor programs, an increase of \$24 million from FY 2008. The request includes \$7.5 million for a new case management system for the foreign labor programs, \$5.7 million to assist states in processing anticipated H-2A and H-2B workload increases, \$4.0 million for Federal staff to process anticipated workload increases, and \$6.2 million to restore funds for inflationary costs not provided under the FY 2008 Omnibus appropriation. This system will allow on-line application filings, replace four separate systems with a single integrated system, and combat fraud by allowing ETA to track employers' use of the various programs.

In FY 2009, the Department will complete its reforms to the H-2A and H-2B Temporary Labor programs. The budget also proposes legislation to authorize cost-based, employer-paid application fees in the foreign labor programs to cover the costs of running the programs. This will enable the programs to efficiently manage the workload with a predictable funding source. It is essential to prevent the re-emergence of backlogs in the PERM program, and to streamline processing under the temporary programs.

Reintegration of Ex-Offenders

The FY 2009 Budget requests \$39.6 million for the new consolidated program, begun in 2008, that brings together the President's Prisoner Re-entry Initiative and the Responsible Reintegration of Youthful Offenders program. Through competitively awarded employment-centered grants, which address the multiple challenges facing offenders upon their release, the Reintegration of Ex-Offenders program will tap the unique strength, networks, and relationships of faith-based and community organizations to reach out to ex-offenders to help them find jobs and build new lives.

Strengthening Unemployment Insurance Integrity and Promoting Re-Employment

The FY 2009 Budget continues the Administration's efforts to ensure the financial integrity of the Unemployment Insurance (UI) system, and help unemployed workers return to work promptly. Our three-pronged approach includes:

- A package of legislative changes that would prevent, identify, and collect UI overpayments and delinquent employer taxes. These changes include: allowing states to use a small amount of recovered overpayments and collected delinquent taxes to support additional integrity efforts; authorizing the US Treasury to recover UI benefit overpayments and certain delinquent employer taxes from Federal income tax refunds; requiring states to impose a penalty on UI benefits that individuals obtain through fraud and using those funds for integrity activities; and requiring employers to include a “start work” date on New Hire reports to help identify persons who have returned to work but continue to receive UI benefits. We estimate that these legislative proposals would reduce overpayments of UI benefits by \$5.0 billion and employer tax evasion by \$400 million over ten years.
- A \$40 million discretionary funding increase over the FY 2008 enacted level to expand Reemployment and Eligibility Assessments, which review UI beneficiaries’ need for reemployment services and their continuing eligibility for benefits through in-person interviews in One-Stop Career Centers. This initiative has already yielded quicker returns to work for UI beneficiaries. We estimate that a total of \$155 million in benefit savings could result from this investment.
- A legislative proposal to permit waivers of certain Federal requirements to allow states to experiment with innovative projects aimed at improving administration of the UI program, and speeding the reemployment of UI beneficiaries.

We urge the Congress to act on these important proposals to strengthen the financial integrity of the UI system and help unemployed workers return to work.

Senior Community Service Employment Program

The FY 2009 Budget requests \$350 million for the Senior Community Service Employment Program (SCSEP). At this level, SCSEP will support 72,000 participants. This program was rated “ineffective” by the Performance Assessment Rating Tool (PART), largely due to inadequate competition in the grants process, lack of data on program performance and impact, and duplication with other federal programs. Recent legislative reforms, though limited in terms of their promotion of competition, will promote improvement in program efficiency (allowing more participants to be served per dollar), collection of performance data, and share of participants placed in unsubsidized jobs.

Job Corps

The Budget includes \$1.6 billion to operate a nationwide network of 123 Job Corps centers in FY 2009. Job Corps provides training to address the individual needs of at-risk youth and ultimately equip them to become qualified candidates for the world of work. The request includes \$59 million for the construction of new Job Corps centers. In the FY 2006 appropriation act, the Congress directed the Department to transfer the Job Corps program out of the Employment and Training Administration (ETA) into the Office of the Secretary. The

2009 Budget again proposes to return the program to ETA, where it had been administered for more than 30 years, to ensure close coordination with the other job training and employment programs administered by ETA, including the YouthBuild program.

SECURING EMPLOYMENT RIGHTS AND OPPORTUNITIES FOR VETERANS

Veterans' Employment and Training Service

This nation's commitment to our veterans must be honored. No veteran should return home without the support that is needed to make the transition back to private life a smooth and successful one. For the Department's Veterans' Employment and Training Service (VETS), the FY 2009 Budget request is \$238.4 million and 234 FTE. This will enable VETS to maximize employment opportunities for veterans and protect their employment and reemployment rights.

The \$168.9 million requested for VETS to provide state grants under the Jobs for Veterans Act includes an increase of \$7 million above the FY 2008 level and will help approximately 700,000 veterans seeking employment in the civilian workforce. The additional funds will help serve 185,000 Transition Assistance Program (TAP) participants in domestic and overseas workshops, an increase of 25,000 participants above the FY 2008 level. TAP employment workshops play a key role in reducing jobless spells and helping service members transition successfully to civilian employment. The FY 2009 Budget includes \$25.6 million for the Homeless Veterans Reintegration Program (HVRP), allowing the program to provide employment and training assistance to an estimated 15,100 homeless veterans. The FY 2009 request will also enable VETS' staff to more effectively administer the Uniformed Services Employment and Reemployment Rights Act (USERRA) to protect the civilian employment opportunities and re-employment job rights and benefits of veterans and members of the armed forces, including members of the Guard and Reserve and others.

OTHER PROGRAMS

Bureau of Labor Statistics

In order to maintain the development of timely and accurate statistics on major labor market indicators, the FY 2009 Budget provides the Bureau of Labor Statistics (BLS) with \$592.8 million and 2,418 FTE. This funding level allows BLS to focus resources on its core surveys that produce sensitive and critical economic data, including the Consumer Price Index (CPI) and the monthly Employment Situation report. The CPI is a key measure of the Nation's economic well-being that directly affects the income of millions of Americans. To ensure that the CPI is accurate and up-to-date, the Budget includes funding of \$10.4 million to continually update the housing and geographic samples that underlie the index to ensure that these samples fully incorporate the most recent demographic and geographic trends and changes. The current sample was derived from the 1990 Census and has not been updated since the late

1990s. In addition, the budget requests \$8.7 million to cover the rising cost of the Current Population Survey, including enhanced efforts to safeguard respondent confidentiality, secure data, and maintain response rates.

Office of Disability Employment Policy

The FY 2009 Budget request provides the Office of Disability Employment Policy (ODEP) with a total of \$12.4 million and 40 FTE. The FY 2009 Budget reflects the elimination of ODEP's grant-making function, which duplicates those of other Federal agencies. The FY 2009 Budget focuses ODEP on its core and critical mission of providing national leadership in developing disability employment policy and influencing its implementation to increase employment opportunities and the recruitment, retention and promotion of people with disabilities. The request also includes a transfer of \$550,000 to the BLS to finalize ODEP's partnership with BLS in the development and testing, and for BLS to begin and sustain monthly publication, of the unemployment rate for people with disabilities.

Bureau of International Labor Affairs

The request for the Bureau of International Labor Affairs (ILAB) in FY 2009 is \$14.8 million and 58 FTE. In recent years, ILAB has had a very large grant-making function. Several federal agencies have grant initiatives that support the objectives of improving international labor conditions and providing educational opportunities to children. DOL believes funding for such international grant activities should be provided to the Department of State, so it can better coordinate these projects. The Budget returns ILAB to its mission of developing international labor policy and performing research, analysis, and advocacy. The Budget request also includes \$1.5 million to allow ILAB to monitor the use of forced labor and child labor in violation of international standards, as required in the Trafficking Victims Protection Reauthorization Act of 2005.

The requested funding levels would allow ILAB to implement the labor supplementary agreement to NAFTA and the labor provisions of trade agreements negotiated under the Trade Act of 2002, participate in the formulation of U.S. trade policy and negotiation of trade agreements, conduct research and report on global working conditions, assess the impact on U.S. employment of trade agreements, and represent the U.S. government before international labor organizations, including the International Labor Organization.

ILAB will continue to implement ongoing efforts in more than 75 countries funded in previous years to eliminate the worst forms of child labor and promote the application of core labor standards.

Office of the Solicitor

The FY 2009 Budget includes \$108.2 million and 643 FTE for the Office of the Solicitor (SOL). This amount includes \$100.8 million in discretionary resources and \$7.4 million in mandatory funding. The Solicitor's Office provides the legal services that support all of the

five critical priorities of the Department, including litigation and legal advice critical to the success of the Department's enforcement programs. This appropriation level will allow SOL to provide legal services and legal enforcement support for the nearly 200 laws the Department must enforce, including new legislation that Congress recently passed to strengthen mine safety and retirement security. The requested appropriation level is essential to allow SOL to fulfill its primary mission of ensuring that the nation's labor laws are forcefully and fairly applied, and providing the legal assistance necessary to ensure that the Department's mission goals identified for FY 2009 are achieved.

Women's Bureau

The FY 2009 Budget includes \$10.2 million and 60 FTE for the Women's Bureau. This budget will allow the Women's Bureau to continue its mission of designing innovative projects addressing issues of importance to working women and providing information about programs and policies that help women succeed in the 21st century workplace.

President's Management Agenda and Department-wide Management Initiatives

Before I close today, Mr. Chairman, I also want to highlight the Department's sustained efforts to implement the President's Management Agenda (PMA). In August 2001, President Bush sent to Congress his Management Agenda, a strategy for improving the management and performance of the Federal government. The PMA called for focused efforts in the following five government-wide initiatives aimed at improving results for citizens: Strategic Management of Human Capital; Competitive Sourcing; Improved Financial Performance; Expanded Electronic Government; and the Performance Improvement Initiative (formerly Budget and Performance Integration). DOL is also responsible for three of the PMA initiatives that are found only in selected departments: Faith-Based and Community Initiative, Real Property Asset Management, and Eliminating Improper Payments.

I am proud to say that, in June 2005, the Department became the first Cabinet agency to earn "green" ratings in all five government-wide PMA initiatives. Two-and-a-half years later – as of the December 31, 2007 President's Management Agenda scorecard – I am pleased to note that DOL has maintained its "green" scores and momentum. In addition, by the close of FY 2006, the Department had achieved two additional "green" ratings -- for its efforts to Eliminate Improper Payments, as well as effective implementation of the President's Faith-Based and Community Initiative to combat unemployment, prisoner recidivism, and other social ills. In recognition of our efforts since 2001, DOL has been honored with four President's Quality Awards from the Office of Personnel Management for our achievements and management excellence in implementing the PMA.

The Program Assessment Rating Tool, or PART, remains central to our efforts at the Department of Labor to improve the performance of our programs. To date, thirty-five DOL programs have been assessed through the PART. The PART assessments have not only been useful to informing the public and policy makers of our programs' strengths and weaknesses,

but they have provided our programs and their managers a systematic method of self-assessment. A PART review helps inform both funding and management decisions aimed at making programs more effective. The Department is actively implementing program improvements identified through PART assessments – and looks forward to building upon our progress to date.

CONCLUSION

With the resources we have requested for FY 2009, the Department will continue its strong enforcement of worker protection laws, provide innovative programs to increase the competitiveness of our nation's workers, secure the employment rights of veterans, and maintain fiscal discipline.

Mr. Chairman, this is an overview of the programs we have planned at the Department of Labor for FY 2009.

I am happy to respond to any questions that you may have.

Thank you.

WIA FUNDING

Mr. OBEY. Thank you.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

Madam Secretary, you just talked about the Workforce Investment Act funding rollover. Can you update the Committee on how much carryover exists within the WIA grant programs and explain why such balances appear to be necessary?

Secretary CHAO. In the time that we have been here, first of all, I want to emphasize that people in the system are all caring professionals. We all care about the system. We all want to make sure that it is effective, that it is helping workers by providing relevant training that would actually allow them to access real jobs that are developing in our economy.

In the past seven years, we have seen year after year carryover in unspent balances that total about \$1,200,000,000 to \$1,700,000,000 a year every single year. This year it is a little bit lower than that because of several other developments, and they range across the board.

What happens a lot of times is the workforce investment systems throughout the States may contract for a training program, but those slots that they contract may not actually be used, so it would be claimed that the money is obligated because they contracted 400 training slots, 800 training slots, but at the end of the year, whether those training slots are actually used is questionable. Many times it is not, so you have the unspent balances. But the system will claim—and we are working with them—that there are unspent balances because they are obligated, but there are two very different points of view about the money.

Mr. WALSH. Last year, this Subcommittee voted for a \$350,000,000 rescission in these funds. Ultimately, in conference, it was settled at \$250,000,000. Can you explain the impact on these programs by that rescission?

Secretary CHAO. Those were primarily taken out of—it was across the board. It was primarily taken out of ETA. And we have some very successful programs that have proven to be very effective, like the President's High Growth Job Training program; the Community College Job Training program, which is a partnership with community colleges; and also the Workforce Innovation Regional Economic Development program. These are small amounts—

Mr. WALSH. Would you say there was a negative impact on this program?

Secretary CHAO. We think so, yes.

Mr. WALSH. Pardon?

Secretary CHAO. We think so.

Mr. WALSH. The budget proposes significant changes to this program this year: proposes a 14 percent cut, roughly \$450,000,000 from 2008 level; it proposes to consolidate WIA Adult Dislocated Worker, Youth Activities, and Employee Services Grant programs into a single \$2,800,000,000 State grant; proposes to add 20 percent State match on CAA funds.

The CAA and State match requirement have been proposed in the past but denied by Congress. Why the drastic reduction in WIA programs?

Secretary CHAO. We have had numerous years of discussion and disagreement about the separate funding for dislocated unemployed workers for adults, youth. Basically, the Administration's workforce investment proposal would give governors much great flexibility in deciding how these funds are going to be used, and the rationale is the governors know best what is happening within their workforce investment system.

Most of the money that goes out from the U.S. Department of Labor, as you well know, goes out on a formula basis, and having these separate funding streams puts all these programs in silos that makes it very, very difficult for these programs to work together at the grassroots level. So less than 5 percent of the money stays at the Federal level; all of the money goes down to the State level; the governors keep about 15 to 35 percent, depending on the program; and the rest goes into the grassroots municipalities and counties and cities.

So sometimes there are developing situations in one district that there is a surplus of funds and other areas that are more unemployed workers and there are a lot of funds; and at the State level the governor, even, is unable to shift any of this around. So we are trying to enable the governors to have greater flexibility in deciding how these monies are to be used.

There has been this discussion. It takes a long time for the system to respond. There is a lot of discussion, but I think that discussion is taking place and it is accelerating, and there is growing support for—

Mr. WALSH. Do governors and State legislatures generally support that concept?

Secretary CHAO. Some. Not all governors, but most governors. There is also a partisan element, of course, to this. Sometimes I receive word that—you know, they will ask questions like why do we not have more flexibility. When I say, well, we have a proposal to that effect, so—

Mr. WALSH. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman.

WORKFORCE INVESTMENT ACT

Madam Secretary, thank you for being here. Your testimony does not mention the elimination of the Employment Service outside of the Career Advancement Account, and that was something that we noticed.

This is, from my perspective, not the time to be eliminating this program that matches people who need employment with employers who have jobs to fill. I can tell you that in Ohio we need more of this, not less of this, and more job training resources, as well, to deal with the escalating unemployment rates and dislocations caused by foreign competition. We have been hearing a lot about this in the presidential race the last few weeks.

Where, in your estimation, do you expect the 13 million participants served by the Employment Service to go for assistance?

Secretary CHAO. I do not think we disagree on how we need to help workers. The issue is how should we do so and where does the money go. Our Country has seen a succession of worker training programs that have evolved over time, dating back to the 1960s. We had CETA, then we had JPTA, and then we had Workforce Investment Act. Every new act imposes a new infrastructure on the old, so that we have duplicative infrastructure that are not helping workers. If you go to most One-Stop career centers, on the right is Employment Services; on the left is Workforce Investment Act. Many times they try to talk to each other, but they cannot because they are operating in silos, and they do not work together and they do not talk to one another. Something is really wrong.

Mr. RYAN. So where are these people going to go, the 13 million people that are being served by this program? I am not saying that we do not have bureaucratic problems—

Secretary CHAO. They will be served. They will be served through the Workforce Investment Act, which was passed in 1998.

Mr. RYAN. Well, you are cutting that by \$500,000,000.

Secretary CHAO. Workforce Investment Act and Employment Services train 200,000 people. Our goal is to train 800,000. They will be able to go to the Workforce Investment Act.

Mr. RYAN. So you are telling me and this Committee that the 13 million people that are currently in this program are going to be able to go to—

Secretary CHAO. They are not served only by Employment Services; they are also served by the One-Stop career centers.

Mr. RYAN. So they are going to be able to get the same services through WIA that you are cutting by \$500,000,000?

Secretary CHAO. Yes. That is the key.

Mr. RYAN. That will be interesting. I mean, I cannot believe that.

Secretary CHAO. I would be more than glad to have my people come and update—

Mr. RYAN. The WIA program now serves 900,000—

Secretary CHAO. That is why there are duplicative—what I am saying is there are duplicative infrastructures in place. That is a problem.

Mr. RYAN. So the whole ES budget is a waste, last year, for example?

Secretary CHAO. It is duplicative.

Mr. RYAN. So it was wasted money spent, the whole thing?

Secretary CHAO. You said that before.

Mr. RYAN. I am asking. You are the one eliminating the program, not me.

Secretary CHAO. We believe that—we share common goals. We are in a worldwide economy. We want—

Mr. RYAN. I am questioning that because of the way this budget looks.

Secretary CHAO. Yes. Well, because there is duplicative—they are doing the same thing. We have a Workforce Investment Act that helps workers, that serves unemployed workers. This is a duplicative structure.

Mr. RYAN. So the answer is yes.

Secretary CHAO. Yes.

Mr. RYAN. All the money we put in ES last year was wasted money.

WORKFORCE INVESTMENT

Secretary CHAO. Well, I would invite you to visit a Workforce Investment center, a One-Stop center. You will see Employment Services on one side; you will see Workforce Investment Act on the other.

Mr. OBEY. Would the gentleman yield?

Mr. RYAN. I would be happy to yield.

Mr. OBEY. How can a program that serves 13 million annually be duplicative of a program that serves 900,000, even if the Workforce Investment system provides job matching services? Are not those services available to far fewer people than through the Employment Service?

Secretary CHAO. We have the capacity to take them on. We have the capacity to serve them. That is the whole point.

Mr. OBEY. You may have, but my point is they are not duplicative if you have only got 900,000 people in one program and 13 million in the other.

Secretary CHAO. Those services can—

Mr. OBEY. That means that for 12 out of 13 people the services are not duplicative.

Secretary CHAO. They can be provided with—there are three different levels of services, but, basically, when a person comes in and they ask for unemployment services, that is provided through WIA. That is what WIA was supposed to do. That is what it does. It has the capacity to do so.

Mr. OBEY. I think the numbers speak for themselves.

Thank you for yielding.

Mr. RYAN. I think the numbers do—if they were duplicative, they were both doing the same thing, and you are going to move this group of 13 million people over into the WIA program, you would need additional resources to deal with those 13 million people. They are receiving a service anyway.

We agree to disagree on that, and this Committee is going to do everything in our power to try to correct that.

YOUTHBUILD PROGRAM

One question I have—because time is running—with the YouthBuild Program. I did see that it received a 15 percent cut, I believe. One of the issues with our young people who are trying to retrain is to get them prepared for the green collar jobs and the making sure the energy-efficiency and whatnot as they are building these new homes or refurbishing homes.

Is there anything in your agenda long-term and in the budget this year to start moving this forward to help with maybe like a YouthBuild green-style program, where we are starting to get these kids and teach them the skills that they would need to put solar panels on houses to make sure that the houses are conserving as much energy as possible?

I will let you answer that and yield back.

Secretary CHAO. YouthBuild was just moved over from HUD over to us, so we are in the process. I think the program works great. We anticipate continuing with the way it is. The green projects are not only popular and being considered in YouthBuild, but in other programs as well.

Mr. RYAN. I would like to work with you on that.

Secretary CHAO. Great. Thank you.

Mr. OBEY. Mr. Peterson.

WORKFORCE INVESTMENT CENTERS

Mr. PETERSON. This was not what I was going to talk about, but Representative Ryan's question raises an issue that I have had many directors out there share with me. There is a problem with the system: we have all of these people housed together, which is good, but there is no common boss. You have State employees, you have Federal employees, and you have local employees; and there is no one who is boss over them all. And you will have, on one side, waiting lines where you are going to wait days to see a person, because they cannot see them all, and you have people over here balancing their personal checkbook or reading a magazine because they do not have a customer, and that is the problem with the system; it is not an efficient system.

I do not know what your plan is to fix it, but I will tell you the directors in my district—and I have been there and I have talked to them on the phone—they have been frustrated for years: I am the manager, I am the top guy here, but I do not manage this person, this person, this person; they work for another agency—State, Federal, local. So moving them into one place was good, but we need to have a common manager who allows people to be cross-trained so that we do not have people sitting over here fiddling their thumbs while others are waiting in lines for days.

Do you think that is a fair assessment?

Secretary CHAO. I am sorry I get so hot. I am really passionate about this system. I love the system. I just want it to do—we who are in it have to challenge ourselves to do better, because there are people waiting for our services and they deserve better.

Mr. PETERSON. Do you think that is a problem?

Secretary CHAO. Yes, it is a problem.

Mr. PETERSON. Yes. See, this is the problem: No one has been put in charge, so you have Federal union employees, State union employees, different bosses, different masters, and local employees, and no one who is really boss of them all. They are all providing different things for different people. You may have 20 customers today; I may not have anybody come in today, so I sit there waiting for the next person to come in. I may be busy tomorrow, but I am not busy today, but I cannot help you.

We need to have a hearing on this, Chairman. We need to figure out how we make these centers a one-stop shop where everybody is skilled and cross-trained and we serve people efficiently. It is not an efficient system.

Mr. OBEY. Would the gentleman yield?

Mr. PETERSON. You bet.

Mr. OBEY. I think that is something that is perfectly legitimate for the authorizing committee to consider, because I think the gen-

tleman probably has a good point. My concern, however, is that what essentially we are being told is we have two programs. We are eliminating the big one; we are cutting the remaining one by 10 percent. And somehow that is going to solve the problem? That does not compute.

Mr. PETERSON. Yes, but I think if we looked at it, we might see where, if you do have a lot of people sitting not efficient, then there is a lot of money there that is being wasted, and I think that is the case. I have had all the managers that manage them tell me, John, we need to put these programs somehow together so there is a common manager in charge for productivity, for serving the people, not just a portion of them. If we are going to put them all in one office, let's make them work together.

Does that make sense to you?

Secretary CHAO. Yes, very much so. And so long as we are talking about reforms, which is what we have been trying—and I know this is not this Committee—one of the other reforms is these are supposed to be One-Stop centers. We also need the cooperation of other Departments to make sure that their services are also included within the WIA One-Stop center, so that people who go to these centers for help do not have to go to 16 or 17 different program offices to get the help that they are supposed to get. But that is another—

SKILL TRAINING

Mr. PETERSON. I want to talk about another issue. I think the growth of the economy in our country, one of its deterrents, I just have companies every day say that as we succeed, we are getting very high tech. Our manufacturing processing cost is very high tech. We have very sophisticated equipment; that is how we compete with cheap labor. It is the only way we can compete. But we do not have the people to run the machines; we do not have the people who know how to fix the machines, maintain the machines, because we are so far behind on the skill training.

I guess do you find it frustrating that the Department of Education again wants to cut—what is the program?

Secretary CHAO. Voc Ed.

Mr. PETERSON. Yes, Voc Ed. But what was the member's name that it was named after? Perkins, yes, Perkins. God, I can't believe I did not think of Perkins.

But these programs get cut, which are seed corn for my local vocational schools and for my—I do not have community colleges, but for community colleges where they have them.

Secretary CHAO. Perhaps you should ask Margaret Spellings that question.

Mr. PETERSON. Do you find it frustrating—you are in your final year, like me; we can say it like it is. They can only fire us. They cannot fire me.

Secretary CHAO. I am very concerned about partnering with community colleges, and you and I have talked about that.

Mr. PETERSON. Yes.

Secretary CHAO. Especially community colleges in rural areas. That is why the Community College Job Training program was important, because we had hoped to set up partnerships with commu-

nity colleges which offer such relevant curricula and they are so responsive to the changing economic needs within the community. So community college partnerships are good; we want to partner with them on that.

Also, distance learning is another phenomena that is prompted by advances in technology that we hope will have great promise as well.

Mr. PETERSON. See, the problem we have, though, is our system assumes that there is a training program in place and you are just going to help pay for it. In my district we do not have a community college. Most of the trades are taught by a few schools. They get \$25,000 to \$27,000 for a 14-month program, which is a compressed two-year program. So \$3,000 two years in a row gives them \$6,000. You know, another \$20,000 needed, poor people cannot do that.

I mean, the poorest among us who need this training, who can be skilled workers are froze out in Pennsylvania, they do not have a chance. That is a Pennsylvania problem, but I am sure there are other States that are like that, because I have 20 percent of Pennsylvania and there is not a community college within 75 miles of my district. So we just do not have that kind of training, we only have private schools; and very few of them, and many things you cannot be taught.

Nobody teaches PLC repair in my district, and every company in my district has PLC computers running their machines. But nobody is trained in my district. We do not have anybody training auto mechanics within my district. Auto mechanics in my district for adults.

We used to ship people over to Pittsburgh, house them to give them a skill after they lost their job. Pretty expensive. Then a lot of times they never came back because some company in Pittsburgh hired them once they had the skill. Real problem in rural areas like mine. But that is the problem, the system assumes you have training. Smart States do. Pennsylvania does not.

Secretary CHAO. Thank you.

Mr. PETERSON. Is my time up?

Mr. OBEY. Thank you. We have a roll call going on, as you can see. What I would like to do is have Mr. Honda take his questioning yet. That would still give us five minutes to make the vote and then the rest of us can come back.

My understanding is there will be two votes, this 15-minute vote followed by a 5-minute vote, and then the next votes will not come for probably an hour to two hours.

Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman.

WIA RESCISSION

Welcome, Secretary Chao. In 2008, the omnibus appropriations negotiations during last year's hearing, you and the President insisted on a rescission of about \$335,000,000 in excess State grants, funds for Youth, Adults, and Dislocated Worker training programs under Title I of the Workforce Investment Act. This rescission has had a direct impact on my district, forcing the award-winning North Valley Job Training Consortium to close its doors every Fri-

day because they do not have enough funding resources to offer their services to my constituents.

I guess the basic question is how do you defend a request to cut Training and Employment Services by 14 percent from last year and how do we keep these programs going with the increase in unemployment, increased need for these trainings? I heard you say there are duplications, but in that area I do not see that duplication, so perhaps you can tell me how we defend a cut.

Also, maybe you can tell me where in my district these duplications are occurring.

Secretary CHAO. I answered the Congressman, Ranking Member Walsh's question wrong. I understand your question now. He was asking about——

Mr. OBEY. Could you pull the mic closer, please?

Secretary CHAO. Sorry about that.

You were also asking about the rescission. The rescission came through because of the overhang in balances. In the last seven years, there have been excess balances of about \$1,200,000,000 to \$1,700,000,000. Because of the rescissions, this year it is only about \$875,000,000. This is a huge issue, and it will come up every year. The issue is we fund this huge Workforce Investment system and are we truly helping workers to train for the jobs of the 21st Century? And there is disagreement about that.

So I do not know specifically what is happening in your district; I should, and I would be more than glad to send someone, if you would like, to talk with you about that. But there is duplication. Notwithstanding the talks that have been here, there has been disagreement about where the duplication occurs, how the system works——

Mr. HONDA. Madam Secretary, I understand duplication. I understand funding unfilled positions. It seems to me that if you folks know that those are occurring, then targeting those areas that have done that and making them expend, or carry over, or make some sort of adjustment rather than just cut across and say everybody suffers because some have not followed the rules, or some have displeased the Administration seems like it is a nice long swipe of one brush hitting good programs as well as those who are not.

Secretary CHAO. Most of this is in formula funds, so basically the States could do whatever they want with it. It is formula funding.

Mr. HONDA. So it is the States' fault?

Secretary CHAO. No, I am not—but there is this overhang. California has—I do not know what California——

Mr. HONDA. I guess I am just trying to argue for the programs that are successful——

Secretary CHAO. No, I understand.

Mr. HONDA [continuing]. And watching their funds and then have to close down——

Mr. OBEY. Would the gentleman yield?

Mr. HONDA. Yes.

Mr. OBEY. You keep mentioning the overhang, but is it not true that a good number of States are not in fact returning prior year funds, but, in fact, they are returning this year's operating money?

Secretary CHAO. I do not think so, but you are——

Mr. OBEY. I think so.

Secretary CHAO. The overhang occurs. You are such an expert—I will look into that for you, but that is not my understanding.

Mr. OBEY. I mean, let me be clear. It is not just the Administration. The numbers are the Administration asked for \$335 million in rescission. The bill that we sent to the President, which he voted, contained \$245 million. The final bill that we sent to the President contained \$250 million. So we reduced the magnitude of the cut in order to finance the amendment that Mr. Walsh and I were both interested in with respect to special education. So I think, to be fair, we need to recognize that both ends of the Avenue are a might responsible, with somewhat greater responsibility in the Administration's hands because they pushed for the larger rescission.

But I would ask you to check to see whether or not you do not in fact have States turning back present year money.

Secretary CHAO. We did not have a choice about that. I understand that you are saying.

Mr. OBEY. Is that it? All right, why do we not go vote and we will resume as soon as we get back.

[Recess.]

VETERANS' TRAINING PROGRAMS

Mr. OBEY. Madam Secretary, I was trying to stall until another member got here who I thought wanted to ask some questions, but I am going to proceed with some of my own until they get here.

You indicated in earlier discussion today that you were taking care of veterans' training programs, and your budget does include an increase of \$10,300,000 for Veterans' Employment and Training Services.

The largest component of that increase is for State grants that support disabled veterans' outreach specialists and local veteran employment representatives. But, as I understand it, those veteran employment specialists work in the State Employment Service Agencies, the same agencies whose funding is being eliminated by the Administration's budget.

How does that make their job easier?

Secretary CHAO. Well, as I mentioned, that is proposing an increase of \$2 million. It is an increase of \$2 million to the Homeless Vets and Reintegration program, \$7 million for the TAP program to help veterans transition more effectively back into the workforce, and we also work with other agencies, as you mentioned.

I am not aware. I shouldn't say that. I am not familiar with the cuts in the other agencies you are mentioning.

Mr. OBEY. No. My point is simply that you are talking about the increase that you are providing for these veterans' employment folks, but if they work in the State Employment Service Agencies and you are eliminating the funding for that, how does that improve their working conditions?

Secretary CHAO. Because we have vets' representatives and coordinators in WIA.

Mr. OBEY. Well, same question, WIA is a much smaller operation.

Secretary CHAO. WIA has the capacity to take on a lot of the employment services.

Mr. OBEY. It may have the capacity, but right now the veterans people aren't housed there to a large extent, to my knowledge.

Secretary CHAO. They are also in WIA. We are trying to consolidate these two systems so that it is for ease of access for clients.

Mr. OBEY. I understand, but if we are trying to gauge the effect of this system on veterans and the ease with which they have access and the opportunity they have for access, it seems to me that if you are shutting down the major offices in which they work, that is not exactly making things easier for veterans. That is my only point.

NONCOMPETITIVE AWARDS

You heard a lot about earmarks. The President has given us the benefit of his wisdom on earmarks on many, many occasions, and yet the Administration conveniently forgets that earmarks are simply directed spending.

In the congressional context, they are spending directed by the Congress, but the executive branch has the functional equivalent of earmarks many times over. They direct a lot of spending, and one area where you do that is the President's High Growth Job Training program.

As I understand it, over 85 percent of the 150 awards made the first 5 and a half years out of that initiative were made on a non-competitive basis. Why isn't every one of those awards on a non-competitive basis, an earmark?

Secretary CHAO. That was only for the first year to get the program going. That is all.

Mr. OBEY. But I repeat the question.

Secretary CHAO. Do I have to answer it?

Mr. OBEY. Why isn't that an earmark or do you agree that it is an Administration earmark?

Secretary CHAO. I never thought of it that way.

Mr. OBEY. That is the problem. The President apparently hasn't either, and that is what has so many people, I think, on both sides of the aisle more than a little irritated with the President's attitude on this.

My understanding is that those non-competitive awards accounted for \$258 million or 90 percent of the funds awarded, and it took language in the fiscal year 2007 and 2008 appropriation bills to ensure that this practice would end.

The Inspector General, as I understand it, is following up with a second audit that will focus his findings, that matching requirements which were often used to justify sole source procurement were dropped in later grant modifications, potentially resulting in service levels below those intended in the original grants.

Let me ask, why was it necessary to provide those grants on a non-competitive basis?

Secretary CHAO. First of all, I believe those were only done in the first year to get the program started, and again the effort started because of an overall effort, overall initiative to try to get.

Mr. OBEY. You are not saying that that money was only provided that way in one of the five and a half years, are you?

Secretary CHAO. They were not sole source the whole entire time. It was only in the beginning.

Mr. OBEY. Well, no, not the last two years because we forbade it.

Secretary CHAO. No. It was before that we did it. These were grants that were related to a program that highlighted what were the high growth industries in our Country that needed skilled workers.

Mr. OBEY. You can put in the record what your understanding is.

Secretary CHAO. Okay.

Mr. OBEY. I will put in the record what my understanding is, but my question remains. Why was it necessary?

Secretary CHAO. Do you have to go through it?

Mr. OBEY. Why was it necessary to, in fact, earmark those funds whenever it was done?

Secretary CHAO. They did have to go through the Procurement Review Board.

Mr. OBEY. I mean what is sauce for the goose is sauce for the gander.

Secretary CHAO. No, it is not. They also have to go through the Procurement Review Board.

Mr. OBEY. Well, we have a review board too. It is called the Appropriations Committee.

Secretary CHAO. Well, that is fine.

Mr. OBEY. My question is why was it necessary to provide these contracts on a sole source or non-competitive basis?

Secretary CHAO. Because the program was to find High Growth Job Training programs. Many of the training programs that are being offered right now are not relevant, and they don't help workers. Unemployed dislocated workers get real jobs in the real economy.

Mr. OBEY. What does that have to do with whether or not you had a competitive grant rather than a non-competitive grant?

Secretary CHAO. These were started out with a very systematic program in which discussions were held with a wide range of employers.

Mr. OBEY. My, isn't it interesting that there is suddenly justifications that develop for directed spending when the Administration does it but not when the Congress does it.

Secretary CHAO. Okay, that is fine. We will submit for the record. No. I am not going to defend this one. Okay? If you want it, we will work with you on it.

Mr. OBEY. I think I made my point.

Secretary CHAO. Yes.

Mr. OBEY. Let me suspend the rest of my questions for now and turn to other members now that they are here. Where did we leave off? It was Mr. Honda.

Mr. Simpson.

Mr. SIMPSON. Thank you, Mr. Chairman. I don't think you want to get into the argument with earmarks. Have you read the article this morning about the *Memo Questions to Fairness of Bush Earmark Decisions*? Kind of an interesting article.

Mr. OBEY. Yes it is.

Mr. SIMPSON. Anyway, that has nothing to do with these hearings today for me.

EMPLOYMENT PROGRAMS FOR VETERANS

Secretary Chao, I appreciate your being here today. Since this probably will be the last time you will appear before this Committee, I suspect, I want to thank you for your service to this Country over the past several years.

You mentioned in your report on your accomplishments that you have implemented a number of new programs to assist America's veterans. Having been Chairman of the Veterans' Benefits Committee, I have always been very interested in what we do there after passing the Jobs for Veterans Act and stuff like that. How are we doing with our veterans in terms of their employment?

Secretary CHAO. It is an absolute priority with us. We have made substantial progress in anticipating and educating and outreach with employers to ensure that they know what the reemployment and employment rights of veterans are.

The Congress passed USERRA in 1994. Nothing was done about it until we came along and implemented, issued regulations which took quite a long time because they were very prescriptive, very detail-oriented relating to pension rights, employment rights, and that came out in 2004. Those regulations have gone a long way toward increasing employer awareness as to what their obligations are and in decreasing the complaints by veterans.

Mr. SIMPSON. As the veterans start returning from Iraq, hopefully sooner rather than later, obviously there are going to be a lot of veterans that are going to be looking for jobs.

Secretary CHAO. That is why we also, sorry.

Mr. SIMPSON. What are we doing to anticipate those increased demands?

Secretary CHAO. Yes, that is why we increased our support for the TAP program. These are counseling, job employment programs that are held overseas so that we don't have to wait until the veterans come back or are separated from the service before they are informed as to what the options are and how they can utilize many of the services available to them.

Mr. SIMPSON. We have officers or we have people overseas that are trying to match up employees so that veterans, when they are getting ready to be discharged from foreign locations, can access employment opportunities.

Secretary CHAO. Yes.

H2B VISA PROGRAM

Mr. SIMPSON. Another question that comes up consistently, at least over the last year or six months, whatever, is concern in Idaho and I think across the Nation by employers about their inability to hire employees under the H2B visa program and that we have a statutory cap on that. Congress hasn't raised that statutory cap this year.

Is the Administration doing anything to try to address that?

Secretary CHAO. The President has asked the Department to work on reforming H2A, and that has come out. It is open for comments, and we encourage people to submit their comments.

That is a very important program. We want to encourage workers to come here legally, so they don't have to live in the shadows.

H2B is, as you mentioned, more driven legislatively. There is a statutory cap which the Administration can't do very much about.

Mr. SIMPSON. Have you recommended lifting that cap to a higher number? I mean I think the cap is something like 60 some odd thousand.

Secretary CHAO. Sixty-six thousand, yes.

Mr. SIMPSON. Sixty-six thousand for the entire Country.

Secretary CHAO. It is used up very quickly.

Mr. SIMPSON. Yes, by the middle of February probably.

Secretary CHAO. Yes.

Mr. SIMPSON. So, consequently, we have employers all across this country who are looking for H2B employees but the cap has already been met and Congress doesn't seem willing to address that.

Sometimes I think that it is time to put pressure on Congress to do a comprehensive reform package rather than what Congress wants to do, and that is secure the border and improve our visa programs and then deal with the rest of the problem.

Secretary CHAO. The cap is statutorily driven.

Mr. SIMPSON. That is the problem.

CARRYOVER IN THE WORKFORCE TRAINING PROGRAM

Just one other question, you mentioned when Mr. Walsh was talking to you about the carryover in the workforce training program. You talked about this last year, and I can't remember if we asked the same questions, but you said there was \$1,200,000,000 to \$1,700,000,000 in unspent funds in the States.

I didn't get the idea whether you thought that was an excessive amount or not enough. I understand there is going to be carryover in the States. What is an appropriate level of that?

Secretary CHAO. Well, we hope that it is used up and that it is used to help workers who need training and jobs, and the Workforce Investment Act has the capacity to provide those employment services as well as the training and core services that workers need.

Mr. SIMPSON. But I am trying to get a sense of whether \$1,700,000,000 or \$1,200,000,000 is too much in funds out there that are unspent and should be spent on this program or whether that is a normal amount for carryover between the 50 States, I guess.

Secretary CHAO. Every year, it is that same amount. So that does indicate excess capacity and that perhaps better utilization of the funds or better management of the funds is something that we should be looking at.

Mr. SIMPSON. But that could be reduced some.

Thank you. I appreciate it.

Mr. OBEY. Thank you.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

UNION ORGANIZING

Secretary Chao, I am here today to express my concern about your Minneapolis investigators' treatment of several of my con-

stituent building and construction unions regarding the filing of several of their LM-2 reports. These actions threaten to impair the fundamental rights to organize a union.

These investigators of yours are insisting that the union submit on the public record, itemized and detailed reports of their confidential organizing-relating expenses on market recovery programs. Now it is my clear understanding that these unions have a legal right not to divulge such confidential information because it would impair their prospective organizing strategy.

Your investigators have reported to the unions that they will be turning the matter over to the Solicitor of Labor to pursue litigation against these Minnesota unions. In preparation for such litigation, your investigators are visiting union offices and inquiring about unions' organizing practices.

Now I have done some looking around, and I am not aware of any other such similar harassing conduct towards unions in any other part of the United States. To me, this is unacceptable, and I am asking that you stop the harassment immediately.

Your investigators have failed repeatedly to cite any provision of Federal Law or any case law to support their positions.

I am aware of a concerted campaign against the legal protected market recovery programs by certain political organizations, and I hope that your investigators have not been unduly influenced by these organizations into twisting the law, into bullying unions in discussing their confidential—their confidential—organizing information since Federal law is very clear, explicitly clear, that they do not have to make such disclosures.

I hope this is a mere oversight of the Department and that when your office has taken an opportunity to look into this, the investigators will stop this unfair treatment.

I have a copy of the letter that I received from the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry, the United States and Canada, for you, and I have one also for the record, Mr. Chair.

With that, if you wish to make any comments, I am fine to hear it. Other than that, I expect that I will hear back from you shortly. Thank you.

Secretary CHAO. We are all for transparency, and I will be more than glad to take a look at that.

[The information follows:]



Founded 1889

Letters should
be confined to
one subject

UNITED ASSOCIATION
of Journeymen and Apprentices of the
Plumbing and Pipe Fitting Industry of
the United States and Canada

UA Local Union: 34

Subject: LM-2 Reports

Business Manager
Stanley L. Theis

*Business
Representative
Financial/Secretary*
Thomas P. McCarthy

Field Representative
David Cormier

*Business
Representative
Mankato Area*
Jack Vota

February 6, 2008

Congresswoman McCollum
165 Western Ave North
Suite #17
St. Paul, MN 55102

Dear Congresswoman McCollum:

I want to thank you for your interest in the harassment that St. Paul and Mankato Plumbers Local #34 and other labor organizations are experiencing from the U.S. Department of Labor's Minnesota field office over the filing of our LM-2 forms.

As you may know, labor organizations are legally required to itemize total receipts or disbursements of \$5,000 or more on our annual LM-2 forms, which are submitted to the U.S. Department of Labor (DOL). These forms are posted on the DOL's website for the whole world to see. However, there is an exception to the itemization requirement for any information that would reveal confidential information about the union's prospective organizing strategy. Local #34 uses its Market Recovery Program (MRP) to organize and promote job opportunities for its members. Therefore, Local #34 exercised our legal right under the federal regulations to decline to itemize our market recovery grants on the LM-2 form. Such disclosure to the general public, and particularly the non-union employers we are trying to organize, would harm our prospective organizing strategy.

Although the National Labor Relations Board has in fact acknowledged that MRPs can, and are, used for organizing purposes, the DOL is wrongly applying the law and refusing to allow Local #34 to assert our confidentiality rights and decline to itemize our MRP grants on the LM-2 form. Local #34 faces irrevocable harm to our organizing efforts if we are forced to provide these specific details about our MRPs to the general public. If non-signatory contractors can determine when and how Local #34 uses our MRP grants by examining them on our LM-2 form on the DOL's website, they will be able to thwart our organizing strategies, rendering the MRP virtually useless as an organizing tool.

Enclosed please find the legal position prepared by our attorney explaining why labor organizations are not required to itemize disbursements of market recovery program (MRP) grants in Schedule 15 of the LM-2 form. As you can see, federal law clearly allows labor organizations to decline to itemize these disbursements and instead include them more



St. Paul Plumbers Local 34
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St. Paul, MN 55102
651-224-3828
651-224-3820 fax

William P. Hite
General President

Patrick R. Porto
General Secretary-Treasurer

Stephen D. Kelly
Assistant General President

generally elsewhere on the form. Our members can review of itemized disbursements at any time at the union offices, as can the DOL. There is no need for the general public, and in particular the non-union contractors we are trying to organize, to know how we spend our organizing funds.

Again, I appreciate your interest in this important issue. I have also included a sample letter from you to the DOL, in the hopes that you will contact the Department of Labor to inquire about this harassment. Please feel free to contact me if you have any further questions.

Sincerely,

Thomas P. McCarthy
Business Agent/Financial Secretary

Enclosures - 2

U.S. Department of Labor

Employment Standards Administration
Office of Labor-Management Standards
Washington, D.C. 20210



APR 16 2008

The Honorable Betty McCollum
U.S. House of Representatives
Washington, D.C. 20515

Dear Congresswoman McCollum:

I write in reference to the February 6, 2008, letter to you from Thomas P. McCarthy, Business Agent/Financial Secretary of Plumbers Local 34 in St. Paul, Minnesota, which you raised with Secretary Chao during the recent hearing of the Subcommittee on Labor, HHS, Education Appropriations. Mr. McCarthy's letter concerns the reporting of a labor union's market recovery disbursements on its Form LM-2, Labor Organization Annual Report. Mr. McCarthy characterizes the position of the U.S. Department of Labor's Office of Labor-Management Standards (OLMS) and expresses his disagreement. Although OLMS cannot confirm or deny the existence of an open investigation, the following explanation of the reporting requirements of the Form LM-2 may provide some necessary context.

The Form LM-2 instructions require "major" disbursements be "itemized," i.e., reported individually as separate line items with detailed information. A "major" disbursement consists of 1) an individual disbursement of \$5,000 or more, or 2) total disbursements to a single entity or individual that aggregate to \$5,000 or more. If itemization would reveal certain types of confidential information and thereby harm the labor union, the union is relieved of the obligation to itemize. For example, if itemization would expose and impair a union's organizing strategy, the union may forgo itemization.

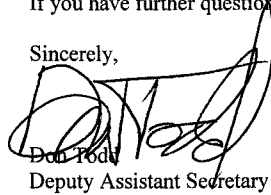
To satisfy the criteria for invoking the confidentiality exception to the itemization requirement, the reporting union must demonstrate that itemized disclosure would be adverse to the union's legitimate interest. The Form LM-2 instructions provide that, in such cases, "the union must be prepared to demonstrate that disclosure of the information would harm an organizing drive. Absent unusual circumstances, information about past organizing drives should not be treated as confidential." If the confidentiality criteria are met, the union need report only general information, without identifying the name of the payee, the date, or the amount of the transaction. If itemization would *not* reveal sensitive information, the union must itemize major disbursements.

The mere fact that market recovery disbursements are used for organizing activities does not necessarily mean that the criteria for invoking the confidentiality exception have been met. Indeed, many labor organizations itemize market recovery payments on the Form LM-2. For example, thirty-eight (38) local labor organizations affiliated with the UA Plumbers itemized payments to contractors furnished as part of a market recovery program. However, OLMS

would not seek to take an enforcement action against a labor union, in any case, for failure to itemize reporting of market recovery payments until it determined after an investigation that the union failed to satisfy the confidentiality criteria.

If you have further questions regarding this matter, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Don Roddy", written over a horizontal line.

Don Roddy
Deputy Assistant Secretary

Mr. OBEY. Mr. Udall.

Mr. UDALL. Thank you, Chairman Obey.

EEOICPA PROGRAM

Secretary Chao, as you know, the EEOICPA program is particularly important to me. For two years, I have been working to preserve an archive of medical records at the Los Alamos Medical Center that are vitally important to hundreds of claimants, yet they are now slated for destruction.

Through this two-year process, your Department has taken a pass at being involved in protecting these records even though the EEOICPA law stipulates that DOL must assist in obtaining DOE materials that are relevant to claims. Why have you been unwilling to assist in this process and will you commit today to helping to preserve these important documents?

Secretary CHAO. I am surprised to hear that from you because EEOICPA is a program that we have been very concerned about. We have taken the lead and, in fact, I think we have worked very hard to be advocates of workers who have been adversely impacted by having worked in the Cold War uranium facilities. So I am disappointed to hear that if that is indeed true, and we will do everything we can to work with you on that.

Mr. UDALL. I think it is true that your Department, much better than some of the other agencies, has worked on some of these claims but in this particular case, this is a group of records from many years at the Los Alamos Medical Center, and they apply to many, many claimants. The records are slated for destruction, and probably these claimants will not have claims if that happens.

Secretary CHAO. Is that Department of Labor or is that Department of Energy?

Mr. UDALL. It is Department of Labor.

Secretary CHAO. Okay. I will take a look at it.

Mr. UDALL. EEOICPA is your program.

Secretary CHAO. No. It is joint. No. We work with the Department.

Mr. UDALL. Well, I know. Yes.

Secretary CHAO. We are the face to the public, unfortunately.

Mr. UDALL. But you have. For example, look at the situation you normally would exercise. Last year, when a Colorado vendor was required to produce evidence related to beryllium, you issued subpoenas. You asked for records. You went out and were very aggressive.

This is the same circumstance. You have a depository of records with a medical center. The medical center is saying they are going to destroy the records.

Secretary CHAO. I am just trying to figure out where these documents are, so I can find them. I just want to make sure, and we can work with you on that.

Mr. UDALL. Yes, yes, yes. They are in Los Alamos. They are in Los Alamos.

Secretary CHAO. I need to find out where they are. Who has possession of them?

Mr. UDALL. The Los Alamos Medical Center has possession of the records.

Secretary CHAO. Okay. That is probably Energy then.

Mr. UDALL. They apply to a number of claimants that either are to file with your Agency or have filed with your Agency.

Secretary CHAO. If it is with another department, Congressman, we may need your help.

Mr. UDALL. Okay.

Secretary CHAO. Because if it is HHS or if it is Energy, we want to preserve those records.

Mr. UDALL. You have subpoena power. You have subpoena power for records and people that bring things in and find out what is going on.

Secretary CHAO. Okay.

NATIVE AMERICAN PROGRAM

Mr. UDALL. Secondly, I just want to ask about your budget cuts for Native American programs to the tune of about \$8,000,000, assistance that goes to the largest single impoverished group in the Nation and cuts 3,000 participants who could otherwise have benefits from gaining important work and an important job and skill-based training. In my district, we have thousands of Native Americans who benefit from this program and who use it to better their lives and improve their communities.

Last year, Congress refused your proposed cut in funding, and this year I think many others will strongly support a funding level that reflects the true need.

In your budget in brief, you state that one of your goals for the Native American program is to emphasize training and talent development in high growth and high demand occupations. Can you expand on that goal? Which specific industries or occupations are you targeting?

Secretary CHAO. Our Country is currently experiencing a skills gap. The majority of the new jobs that are being created these days require higher skills and more education. So we are trying to target more of our training resources to help workers get the training that is required, that they need to access good paying jobs in these high growth industries. So it is a much more targeted approach.

I remember well our discussion last year about the Native Americans, and I remember what you say. Unfortunately, we are going to disagree on that because the Administration's policy is not to have separate funding streams. In fact, this is a subject of great disagreement here.

We would like to consolidate all the funding streams so that the governors and the States get greater flexibility in deploying these funds. So I am afraid my answer to you will be the same as last year, that we are going to disagree on that issue with the Native American funding. The funding will be consolidated and it will be gotten through the WIA One-Stop centers.

Mr. UDALL. If, just as you said, higher skills and more education, this is the population that needs it the most. You don't have any problem sending it to a governor that that may not be in his priority. I mean this is a pre-existing situation that has a relationship, and it is targeted to a community that has some real need.

You are just saying we don't care. We just want to ship it back to the State.

Secretary CHAO. No.

Mr. UDALL. Plus, we want to give them less money, I assume too, to do the job.

Secretary CHAO. I am not anxious to disagree with you.

Mr. UDALL. Well, let me just ask you, are you proposing when you shift all these monies back to the States, are you going to give them more money and flexibility?

Secretary CHAO. We would. We can't do that because it is legislatively driven. That is part of the Workforce Investment Act reauthorization that the Administration has been working on. So, currently, it is on a formula basis.

What we are proposing is a consolidation of the Employment Services and Workforce Investment Programs because we believe that is a more effective way to provide training dollars for the dislocated unemployed workers.

Mr. UDALL. Well, it just seems to me that these programs have grown up over time because there is a need there, programs like YouthBuild and many of the others, this Native American program.

I think you are disregarding the input of Congress saying these programs are important. You have been through the process several times. You proposed these cuts.

Secretary CHAO. Yes.

Mr. UDALL. We don't put them in. I mean we don't ratify them. So it seems like there should be another approach here.

Thank you very much, Mr. Chairman.

JOB CORPS

Mr. OBEY. Mr. Jackson.

Mr. JACKSON. Thank you, Mr. Chairman.

Secretary Chao, welcome back to the Subcommittee. Thank you for your testimony.

I apologize for being a bit tardy. We have a number of hearings taking place at the same time.

I would like to ask a couple of questions regarding the Job Corps. Included in the fiscal year 2007 and 2008 appropriations bills was statutory language prohibiting the Department of Labor from reducing student training slots below 44,491, the number of slots the Department operated in the program in year 2006 according to fiscal year 2007 budget requests.

Yet, currently, the Department is operating only 43,459 training slots in Job Corps. That is over 1,000 slots less, an equivalent to closing 3 Job Corps centers. In fact, one Job Corps center in Cherokee, North Carolina has been closed for one year.

Can you explain why the Department has proceeded with reducing the overall capacity of Job Corps despite a statutory requirement prohibiting these actions, Madam Secretary?

Secretary CHAO. About 4,000 of these slots go unused, so these are not at full capacity. We are distributing them around. They are not used, number one.

Number two, the particular Job Corps that you mentioned, North Carolina, we hope that we would actually get your assistance on that because the National Director of the Job Corps closed down that facility because of safety concerns. It was not hygienic. It was

not a good place. We would not want to put our Job Corps students in that facility.

You know who the operator is, and I am not anxious to name them. But we are working with our sister agencies to try to open that up as quickly as we can, but that is not an issue about money. It is an issue about safety.

We saw mold in the ceilings. We saw paint peeling from the ceilings. It was dirty. It was not well maintained. That is a Job Corps facility that needed to be shut down, needed to be refurbished, and we are in the process of opening it up but only with the assurance that the students will be okay to enroll there.

Mr. JACKSON. I appreciate the answer.

I just want to make sure for the record that to answer my first question, there are insufficient number of applicants for the Job Corps to actually satisfy the statutory requirement of the 44,491 slots. Is that your answer, Madam Secretary?

Secretary CHAO. There are about 4,000 slots that go unused, yes.

Mr. JACKSON. It is estimated that three out of five American youth leave school without the skills they need to succeed or work in higher education. According to a recent study conducted by the University of New Mexico, leaving these youth behind costs our economy about \$24,000,000,000 and does not allow our youth to reach their full potential. Further, our Nation is entering an economic downturn.

I am wondering in these difficult economic times, considering the disadvantaged and disconnected youth. I would imagine that amongst them is a tremendous amount of uncertainty.

When national studies, dropout statistics in communities across the Nation and visits to many of our congressional districts make evident that youth are in need of the Job Corps services, I am wondering if you could expand upon this, why the Administration cut the number of training slots by that 4,000, given what at least many of us perceive in our districts as a tremendous need for Job Corps.

At a time when the Nation is facing a possible recession, why would you reduce funding for a program that provides America's young people, critical vocational training and job placement services and activities in the middle of an economic downturn?

I yield back the balance of my time, and I would appreciate your answer, Madam Secretary.

Secretary CHAO. I think we all agree that education and skills training are very, very important for today's workers and for young people, they need to be encouraged to stay, obviously, in school. If they can't stay in school, Job Corps is one alternative. YouthBuild is another.

But we do have, again, 4,000 slots that are not being used. It is not a matter of marketing. It is a matter of takeup rates. There is an excess, so that is why the budget was cut.

Mr. OBEY. Thank you.

Mr. Regula.

GIVING YOUNG PEOPLE A SECOND CHANCE

Mr. REGULA. Thank you, Mr. Chairman.

Happy to see you, Ms. Secretary.

Just a couple questions. One-Stop Career Centers are very effective in our area as you know.

Secretary CHAO. Yes.

Mr. REGULA. I see that you have given them a fairly good number in this budget.

I would be interested in the success of your programs aside from the One-Stops that give young people a second chance, those who get GEDs, who decided after they have dropped out that they need to go back and get a skill, and they discover that the marketplace requires that. Have you had good success in getting development of programs that will provide what I call a second change for people?

Secretary CHAO. We do. Our whole Department's efforts, in fact, focused on helping workers and giving them a second chance, and so we have all these different programs that do offer to do that.

We did have a robust discussion about workforce investment. We have many other programs for young people as well. So that is what the whole focus of the Department is.

The issue was how to do this effectively because the majority of the new jobs that are being created require higher skills, more education. So we cannot continue to train the same way as we used to. We need to gather our resources, focus them on training and make sure that this training is demand-driven and that people who receive this training, who have invested a great deal of their time in training programs will actually get jobs when they graduate.

Mr. REGULA. Do you have programs that let young people know that there is this second chance opportunity?

Secretary CHAO. Job Corps is very, very active in marketing, and we have a whole marketing team out there, yes.

VOLUNTARY PROTECTION PROGRAM

Mr. REGULA. The Voluntary Protection Program—people in my area have been very enthused about it. Has it worked well to keep people safe and healthy in their workplace? I think this is an important program.

Secretary CHAO. VPP is not a substitute for enforcement. Enforcement is important. We, in fact, have one of the most effective enforcement programs as you can see by the injuries and other statistics about worker safety, but enforcement should be coupled with outreach, with education so that all stakeholders within an organization understand the culture, the prevailing culture must have as its core value that safety is number one.

And so, injury and illness rates with VPP companies are actually much lower than the norm, the average.

Mr. REGULA. So you are achieving a measure of success then if they are lower?

Secretary CHAO. Yes.

MARKETING

Mr. REGULA. Lastly, one of the growing phenomenon, the P-16 concept whereby colleges, universities, et cetera will go into a high school and offer courses with a twofold objective. One is to give the students something they can start and maybe transfer in as sophomores in the college program, having gotten it in the senior year

of high school, but I think equally important is to let young people in schools know there is an alternative to going out in the marketplace and not going on to getting higher education. I am talking about higher education in the sense of technical institutes, community colleges and so on.

Does the Department of Labor get involved in any great extent in encouraging these kinds of programs?

Secretary CHAO. We do. One of the things that the ETA focuses on, that the workforce investment system focuses on, the One-Stop Career Centers focus on is outreach and to let people know about the tremendous array of programs that can help dislocated and unemployed workers.

Mr. REGULA. I don't think often times students realize the opportunities that exist out there. So marketing has to be part of your mission, and you mentioned that in your comments.

Secretary CHAO. Talking with high schools students, talking with students about the fast growth industries of the future and where these jobs are going to be coming, where the jobs will be created is a routine part, not routine in terms of not important, but it is a regular part of the responsibility of the Workforce Investment Act professionals.

Mr. REGULA. Thank you, Mr. Chairman.

Ms. Lee? No.

Ms. Roybal-Allard.

JOB CORPS PROJECT IN LOS ANGELES

Ms. ROYBAL-ALLARD. Madam Secretary, as you may know, the Job Corps building in downtown Los Angeles has been deemed seismically unsafe. The YWCA of Greater Los Angeles has been working very closely with the Department of Labor for years on plans to build a brand new and safe Job Corps building, and they are now ready to begin construction.

However, the project cannot move forward without a lease agreement from the Department of Labor. The YWCA has assured me that they are anxious and ready to negotiate with the Department and to come to a mutually acceptable agreement in order to move forward.

Now your Administration was instrumental in initiating this project, and I thank you for that. It also means that you understand the importance of this project to the community as well as to Job Corps and to your Department.

Your staff has indicated that the lease negotiations will receive expedited consideration. Can you tell me if, in fact, the process will be expedited and specifically how long you anticipate the approval process will take?

Secretary CHAO. Congresswoman, I know you are concerned about it, and we are focused on this. Unfortunately, and we could use your help on this, there is disagreement about what the going market rate is.

In the first phase, YWCA wants like \$4,000,000 whereas we value, not we, the Job Corps professionals who do this real estate type of transaction, they feel that the first portion is only worth \$1,500,000.

Ms. ROYBAL-ALLARD. I think they understand that.

Secretary CHAO. Okay.

Ms. ROYBAL-ALLARD. I think they understand there is a difference of opinion.

Secretary CHAO. Right.

Ms. ROYBAL-ALLARD. Let's get together and meet and resolve it so we can go forward because the longer the delay the costlier the project and so on.

Secretary CHAO. Okay. Right.

Ms. ROYBAL-ALLARD. So if you could commit to having that meeting, we would appreciate it.

Secretary CHAO. Sure, absolutely.

HEALTHCARE WORKERS' PROTECTION AGAINST PANDEMIC FLU

Ms. ROYBAL-ALLARD. Okay. Thank you.

It has been over two years since a number of labor organizations petitioned OSHA for an Emergency Temporary Standard to protect healthcare workers against pandemic flu. In addition, an explanatory statement in the fiscal year 2008 omnibus appropriations bill requested within 30 days of enactment a report detailing the timeline for developing and issuing this standard.

The report is overdue. We have not received it, and meanwhile the lack of report is risking a workforce crisis because we have an unenforceable standard for hospitals in place. We should have an order to protect nurses and other healthcare providers.

When will OSHA issue an enforceable standard on healthcare workers' protection and why has your Department ignored the instructions in the omnibus bill to present this within 30 days of the President signing the bill?

Secretary CHAO. If it is within 30 days and we missed a deadline, I will ask about that.

On the issue of the Emergency Temporary Standard, that is very, very prescriptively, well, there are certain standards that must be met. It was in the judgement of the attorneys within the Department that issuing a standard because even though we are concerned about this issue, that it is not meet the imminent danger standard that is required to issue an Emergency Temporary Standard.

But we remain very concerned about this issue. We have put up on the web site and engaged in all sorts of outreach efforts and education efforts on the need to be very vigilant about pandemic flu.

Ms. ROYBAL-ALLARD. Well, obviously, there is disagreement with the healthcare profession but nevertheless, regardless of the difference of opinion, Congress did direct that a timeline be submitted.

Secretary CHAO. Yes. If it is late, I am sorry about that. I was not aware of that.

Ms. ROYBAL-ALLARD. Okay.

THE ROLE OF UNIONS

Finally, the Bureau of Labor Statistics' most recent survey of union membership shows that 15.4 million American workers belong to a union. That is 12 percent of employed wage and salary workers.

BLS data also shows that full-time wage and salary workers who are union members had a median usual weekly earning of \$833 compared with a median salary of \$642 for wage and salary workers who were represented by unions.

In our overview hearing, we heard how deunionization of the workforce has contributed to the growing wage inequality that we are seeing in the economy. The issue is quite simple: union jobs often mean better jobs and better wages.

Protecting those jobs and preparing for job seekers to qualify for them is an important component of a valid workforce strategy. Yet, when you talk about unions, it is never about these positive aspects of unionization.

Can you discuss the role of unions in providing access to family-sustaining wages and what your Department does to support unionized workers, including partnerships to train workers for the highly paid jobs that the unionized segment of various sectors provides, whether it be healthcare, hospitality, manufacturing or construction?

Secretary CHAO. We work with organized labor on ensuring health and safety at the workplace. We have the largest number of health and safety partnerships with organized labor of any Administration.

We also have training partnerships with them through Job Corps, through subcontracting some of our training.

Ms. ROYBAL-ALLARD. I understand, but my question is a little bit more specific. Actually, I am asking for you to discuss the role of unions in providing access to family-sustaining wages. That would be the first part of the question, if you could answer that.

Secretary CHAO. We are going to disagree on this. The skills gap is what is contributing to the wage gap. It is not an issue of income disparity in our view but rather that the majority, increasingly, the new jobs that are being created require higher skills and more education and because of the skills gap, that is why we have an income gap.

So what we have to do is to help workers get the training that they need, which goes back to all of our previous discussions, so that they can develop career paths in these high growth job training industries.

Ms. ROYBAL-ALLARD. Are you disagreeing then with the findings that union jobs provide better wages?

Secretary CHAO. No, I am not. No.

Ms. ROYBAL-ALLARD. Also, let me just end with saying you keep going back to the need for training. But, as my other colleagues have pointed out, the very training programs that workers need to receive that training, you are cutting.

Secretary CHAO. Well, doesn't that speak to the effectiveness of the current training program? Shouldn't we all be looking at how effective are these dollars that we are giving to this training system?

We need to do better. We need to do things differently, and we need to reform the system.

Mr. OBEY. Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman.

I apologize, Madam Secretary, for running in and out, but like most members we have had several meetings today. But, good to see you.

Thank you, Mr. Chairman, for this hearing.

Let me just ask you a couple questions, one with regard to the authorization for the funding for Green Jobs. Is that an initiative that you support and, if so, what is the Administration's plan for investment and growth in this area and what are you doing to ensure that there is a skilled workforce for the green jobs effort in our country?

PLAN TO ADDRESS DISPARITY RATES IN UNEMPLOYMENT

Secondly, let me ask you with regard to what I asked you last year. First of all, let me just reiterate the fact that unemployment rates: the national unemployment rate, 4.9 percent; African American community, almost double, 9.2 percent; Hispanic-Latino community, 6.3 percent; Asian-Pacific American community, 3.2 percent.

Last year, we included language in the omnibus bill that requested you to look at the continuing disparity rates in unemployment for these communities of color, minority groups, and to report to the House and Senate Committees on Appropriations by March 1st a specific plan to address this problem. So I want ask you if you have addressed this issue in your plan.

Secretary CHAO. We do, yes, but the plan is not ready.

Ms. LEE. Pardon?

Secretary CHAO. Yes.

Ms. LEE. You have? When is the plan going to be ready? I think the date was March 1st.

Secretary CHAO. It was. We had hoped to get it ready for this hearing. Apparently, it is not out yet.

Ms. LEE. And so, what happened? When will it be ready?

Secretary CHAO. It is not my Department.

Ms. LEE. Pardon?

Secretary CHAO. It is not in our Department.

Ms. LEE. What department is it in?

Secretary CHAO. It has to go through clearance.

Ms. LEE. Clearance, okay. So do we have an anticipated date?

Secretary CHAO. We are pushing for it.

Ms. LEE. Next 30 days maybe?

Secretary CHAO. I sure hope so. We are going to push for it.

Ms. LEE. Okay.

Secretary CHAO. You are asking for me to push for it?

Ms. LEE. Well, yes. It was due on March 1st.

Secretary CHAO. Yes, right.

Ms. LEE. Okay, thank you.

Then the third question I just want to ask you—the State of California is pursuing Fed Ex for unemployment insurance payments, having determined that the company has misclassified some workers. In December of 2000, the IRS announced it would impose a \$319,000,000 fine on Fed Ex for misclassifying its Fed Ex ground drivers as independent contractors, and that represents just the violations for 2002.

So I want to see if DOL has followed up to determine whether any of these drivers have been denied overtime or other labor rights and benefits.

Secretary CHAO. I will look into it. I mean it is part of what we usually do and if something, if unfair practices have occurred, we need to do something about it.

Ms. LEE. Could you kindly tell us how you would follow up and how we would?

Secretary CHAO. If you give us the information, if the Department is not looking at it already, we will look into it.

Ms. LEE. Okay, so you will look.

Secretary CHAO. Yes.

Ms. LEE. Thank you very much.

GREEN JOBS INITIATIVE

On the Green Jobs Initiative, in terms of funding for training?

Secretary CHAO. Yes, Mr. Ryan was also interested in that, in that issue. We are working with the Energy Department because of the Energy Act. There is a provision for Green Jobs there, so there is a lot. We are currently discussing with them on how to collaborate on setting more of an emphasis on training workers for Green Jobs.

Ms. LEE. Okay, but let me ask you because I haven't seen this in the budget. Are we funding the Green Jobs Initiative in this budget or not?

Secretary CHAO. No. We don't have the appropriate funds. No.

Ms. LEE. We are not. Do you know why not since this is something that we know in this industry creates jobs?

Secretary CHAO. Yes, we thought so, but the answer I was given was that we were working with the Energy Department. We can take another look since you asked.

Ms. LEE. This is the Department of Labor, right, and you do want to create jobs, right?

Secretary CHAO. But we do. We do also, again, go into partnerships with many other departments on the other issues that come up.

Ms. LEE. Yes, but I don't feel and see a sense of urgency within your Department. Given this economic recession we are in, you would think.

Secretary CHAO. There is a sense of urgency. We just differ on how to do it.

Ms. LEE. Well, then, how do you think we should do it?

Secretary CHAO. We have to consolidate. We want to have the career advancement accounts so that we can train more workers, so we can focus more dollars on training workers. That is our vision.

FUNDING FOR WORKFORCE TRAINING

Ms. LEE. Okay. Now, speaking of training, in the budget—again you can correct me if I am wrong—youth training funds for States and localities are reduced to \$841,000,000. It seems like that is a 9 percent cut.

Dislocated worker training funds available to States and localities reduced 6.5 percent below fiscal year 2008 level.

Adult training funds that support State and local services that provide the One-Stop Career Centers, they are reduced by about 17.4 percent. No funds provided for the first quarter.

So, if we are talking about job training and we all recognize that is extremely important, why in the world would we see such significant cuts in these programs?

Secretary CHAO. Because our workforce investment proposal proposes consolidation, and it proposes consolidation of the current system which is duplicative and which does the same things.

Ms. LEE. You are saying everyone is going to get trained. All of our workers will be trained.

Secretary CHAO. There is a better way train through workforce.

Ms. LEE. The way you are talking about consolidating, that we are not going to lose any training possibilities for Americans.

Secretary CHAO. WIA has the capacity which is why you are seeing, in part, the excess balances. WIA has the capacity. We have a duplicative training system, a duplicative employment services system.

New programs are added on. The old ones are not reformed. So we have excess. We have this duplicative system.

Ms. LEE. So no fewer people will be cut from training programs by consolidating?

Secretary CHAO. We hope to increase training of workers from 200,000 to 800,000. Right now, all we train are 200,000 in a vast system of this size.

Ms. LEE. Okay. So consolidating will help increase the training opportunities for more people.

Secretary CHAO. Because it will give more dollars toward the training.

Ms. LEE. Yes, okay. Thank you, Madam Secretary.

NON-COMPETITIVE GRANTS

Mr. OBEY. Madam Secretary, I want to return to the issue of the High Growth Job Training program. You suggested that these non-competitive grants were provided only in one year. That is not what the Inspector General says. So let me walk through what my understanding is of the Inspector General's report.

His report indicates that over 85 percent of the 150 awards made under the first 5 and half years of this initiative were made on a non-competitive basis, that those noncompetitive awards amounted to \$258 million or 90 percent of the funds awarded, and that it took language in the 2007 and 2008 appropriations bills to ensure that that practice would end.

So let me repeat. Of the 150 awards that CRS looked at, spanning fiscal year 2001 through the first half of 2006, only 23 were awarded on a competitive basis. According to the report, they were in response to a competition in late 2004.

So, as I read that, in 5 and a half years, only 1 competition was held and the remaining 127 grants were awarded on a non-competitive basis. That is not a one-year startup, as I read it.

Secretary CHAO. We disagreed with the Inspector General, and we have conveyed our reasoning.

The initial distribution of these grants were sole source, but that was, again as I mentioned, to bring the high growth sectors which

were not included in WIA into WIA so that the system can be responsive in training workers for real jobs that were developing in the real economy. We were training people in the same old, same old for jobs that may not exist.

Mr. OBEY. That is beside the point.

The question is whether your statement was accurate or whether mine was accurate. That is the question.

Secretary CHAO. I believe mine is, but we will go back.

Mr. OBEY. I think you need to because the Inspector General states clearly—states clearly—that that's not the case.

Secretary CHAO. We sometimes disagree. Well, we sometimes disagree.

IMPROVING PROCUREMENT INTEGRITY

Mr. OBEY. The Inspector General also included the challenge of improving procurement integrity in his report. He indicated that the Department's acquisition authority exceeded \$1.7 billion and included over 8,800 acquisition actions in fiscal year 2006.

The report from the IG indicates that for several years, he has recommended that the Department of Labor separate program and procurement responsibilities to ensure program integrity.

Why haven't you taken steps to address the Inspector General's recommendations?

Secretary CHAO. The Inspector General would like to put the procurement in the Office of the Secretary which we believe would be a terrible move, with all due respect to the Inspector General.

Job Corps is a prime example. Job Corps was mandated by Congress to be moved out of the Employment Training Administration, so that was done so. In deference to the Inspector General, we moved the procurement out of Job Corps and put it into the Office of Management and Administration. That has been a move that has been very difficult for Job Corps and for Job Corps contractors.

Mr. OBEY. Well, the IG report concludes, "Until procurement and programmatic responsibilities are properly separated and effective controls are put in place, the Department will be at risk for wasteful and abusive procurement practices."

Secretary CHAO. We have great deference to the Inspector General.

Mr. OBEY. I can tell.

Secretary CHAO. There are going to be future Secretaries of Labor that are going to have to deal with this issue, and I have no problem moving it out and implementing this recommendation because my tenure is leaving. My tenure is shortening. But it is not a good move to move it into the Office of the Secretary.

Mr. OBEY. I can tell you don't agree. All right.

Secretary CHAO. Because Job Corps, we already see in Job Corps, some of the implications.

JOSEPH A. HOLMES SAFETY ASSOCIATION

Mr. OBEY. Well, the President's budget for the Mine Safety and Health Administration includes a provision that allows the Secretary to recognize the Joseph A. Holmes Safety Association as a principal safety association. This provision was first included in the

Labor-H Bill about seven years ago at the request of a member of the Appropriations Committee.

Information supplied to this Subcommittee indicates that the Joseph A. Holmes Safety Association receives non-competitive contracts each year, presumably using this language as justification for sole source procurement. The funding is small, but it is also supplemented by official participation of MSHA personnel in the work of the organization.

The Administration, as I understand it, is requesting that we continue this provision in the fiscal year 2009 bill even though we have heard repeatedly that there are no earmarks in the President's budget. Can you tell me why the designation of this organization is not an earmark?

Secretary CHAO. I am not familiar personally with this organization, although I do know. I do seem to remember that this is a longstanding practice that goes back several decades. I believe to the MSHA Act.

Mr. OBEY. It goes back seven years.

Secretary CHAO. No, no, it doesn't.

Mr. OBEY. The question is why is this not considered an earmark?

The President says he is against earmarks. He said he doesn't have any earmarks in his bill. Why isn't this considered an earmark?

Secretary CHAO. I guess it is a matter of definitions.

Mr. OBEY. You betcha. That is our point.

ERGONOMIC STANDARDS

Let me turn to OSHA. Among the milestones in your CPAC address was a reduction in the number of regulations during your tenure. I would like to take a look at how that milestone was achieved.

OSHA has missed all of the deadlines for developing standards that it had set out in its own regulatory agendas over the past seven years except for those imposed by a court.

For some hazards, your Department has balked at issuing standards at all, denying petitions for emergency rulemaking in the cases involving diacetyl which has caused lung disease and, as you know, even death among popcorn manufacturing workers.

Your Department continues to drag its feet on issuance of guidelines to replace the ergonomic standards that the Bush Administration had repealed in 2001.

In our health overview hearing in February, Dr. Paul Leigh told us that the annual cost of occupational injuries, illness and fatalities is over \$160 billion. A significant portion of those injuries are musculoskeletal disorders. In fact, BLS found that those types of injuries accounted for 30 percent of all reported lost time injuries and that those cases resulted in a longer period away from work, resulting in greater impact to employers in lost productivity.

When the ergonomic standards were repealed, the Administration promised to develop voluntary guidelines on an industry by industry basis.

Nearly six years later, not much has happened. Only three voluntary industry guidelines for poultry processing, retail stores and

nursing homes of the 16 recommended by your handpicked advisory group have been issued. In this past year, one additional draft guideline for shipyards was published.

If the government wants to prevent one of the leading causes of workplace injuries and illness, wouldn't it make sense to pay a whole lot more attention to ergonomic standards that are responsible for nearly one third of workplace injuries?

Secretary CHAO. It was on a bipartisan basis that the Congress turned back the last Administration's ergonomic standards. We said that we would come out with standards and, as I mentioned, we have.

On the issue of regulations, when we first came——

Mr. OBEY. Excuse me for interrupting. You can define it bipartisan if you want. I wouldn't. But even if you do, I don't care if it was bipartisan or totally partisan. It was wrong.

The Administration hasn't done diddly to deal with the problems.

Secretary CHAO. Okay. The Congressional Review Act forbids doing the exact same thing as the regulation, that was overturned, required.

Mr. OBEY. Well, but where were you in developing the promised alternative over the last six years?

Secretary CHAO. We have. As I mentioned, we have come up with standards. We have done outreach, education.

Most of all, injuries have actually fallen. The record of injuries has actually fallen.

Mr. OBEY. Well, if you are talking about four of the sixteen and you look at that as a badge of honor.

I just think that the ergonomics area is a spectacular example of where this Administration has ignored its responsibilities both to employees and employers. You do the economy no favor when you allow these kinds of problems to continue and allow OSHA to continue to drag its feet to developing new standards on this or anything else.

Go ahead if you want to comment.

Secretary CHAO. On the issue of regulations, when we first came in, there were 140 regulations. There are currently about 80 regulations which we are working on.

In whittling down the backlog of regulations, we wanted to focus on what could be doable. There were many regulations on the backlog which were there for nearly a decade. So it was more of a concerted effort to focus on what could be done and not to give the regulated community, be they nonprofit or for profit, an unrealistic view as to what was going to be accomplished.

Mr. OBEY. Well, the fact is in my view the Agency has dragged its feet. OSHA has dragged its feet for years in developing these standards. I think a lot of people are experiencing a lot of problems because of it, and I think OSHA has failed in its responsibility to avoid that.

Those are all the questions that we have time for.

Mr. Udall, did you have any other questions before we break?

Mr. UDALL. [Remarks off microphone.]

Mr. OBEY. Thank you for coming.

Secretary CHAO. Thank you.

[The following questions were submitted to be answered for the record:]

CONTRACTING

Mr. Obey: Please update the information of page 531 of Part 7 of the Hearings on the FY 2008 President's request by providing a table including annual DOL contract obligations from fiscal years 2000 through 2007 by operating division, and for the department as a whole. In addition, please include an explanation for the growth in reliance on outside contractors.

Ms. Chao: The table below shows all DOL contract obligations from years 2000 through 2007.

US Department of Labor									
DOL Contract Obligations by Operation Division and FY									
Agency	2000	2001	2002	2003	2004	2005	2006	2007	
BLS	49,748,000	39,920,000	65,355,000	57,349,678	62,978,396	65,852,789	67,719,029	81,088,870	
EBSA	23,834,000	32,498,000	20,083,000	23,811,334	30,923,682	33,437,417	17,343,330	30,861,108	
ESA	41,239,000	74,702,896	65,272,690	70,882,318	79,490,315	79,861,004	100,451,983	135,594,416	
ETA	74,542,000	80,282,000	99,451,561	101,943,266	99,128,276	71,286,707	81,315,753	61,343,115	
ILAB	10,862,000	17,873,000	18,293,000	10,800,974	4,689,033	5,018,634	8,504,168	3,991,141	
JobCorps	964,394,154	1,003,276,791	1,192,295,832	1,121,169,791	1,226,708,449	1,195,577,670	1,302,313,443	1,311,454,076	
MSHA	6,866,000	21,180,000	20,102,066	18,460,195	23,013,795	23,463,315	20,503,483	39,427,761	
ODEP	1,900,000	3,021,000	5,123,908	3,393,817	2,502,162	1,986,384	1,284,645	9,541,227	
OIG	8,954,000	17,589,000	13,444,000	7,172,267	6,316,579	4,717,381	9,896,673	8,499,793	
OSHA	26,399,000	37,779,000	39,262,000	34,230,096	22,870,647	26,600,970	32,240,531	39,484,658	
PBGC	6,065,754	17,473,215	217,241,993	114,148,236	93,117,877	88,522,145	86,584,323	88,847,292	
SOL	4,687,000	3,583,000	4,171,000	4,430,067	2,622,507	2,930,177	3,274,272	4,619,042	
VETS	4,916,000	3,554,000	5,907,000	2,310,126	3,966,341	4,990,909	7,366,156	7,040,362	
DM/WCF*	68,247,000	65,241,230	142,886,437	114,441,545	141,268,443	109,275,713	115,427,948	111,715,868	
DOL Total	\$1,292,653,908	\$1,417,973,132	\$1,908,289,487	\$1,684,563,710	\$1,799,596,502	\$1,713,521,215	\$1,854,225,737	\$1,933,508,729	
*DM/WCF excludes SOL and ILAB (shown separate iv)									

*DM/WCF excludes SOL and II AB (shown separately)

An increase in contracting cost generally was a result of higher contractor labor cost and program expansion. Examples include the construction and operation of four new Job Corps Centers and the transfer of the Energy Employees Occupational Illness Compensation Program from the Department of Energy to the Department's Employment Standards Administration (ESA). ESA also developed and implemented the Integrated Federal Employees' Compensation System to replace a legacy system developed in the mid-1990s. The Office of Assistant Secretary for Administration and Management (OASAM) increased contracting to improve physical security at the Department's headquarters building, to develop a backup facility to support the Department's Continued Operations Plan, to acquire an acquisition processing and management system, and to upgrade security for other administrative systems.

During the period, the Mine Safety and Health Administration (MSHA) consolidated all of its stove pipe data applications into a common platform called MSHA's Standardized Information System. The Occupational Safety and Health Administration (OSHA) also began developing a comprehensive, integrated, and enhanced data system to manage the agency. Much of the Pension Benefit Guaranty Corporation (PBGC) contract costs are driven by the largest plan terminations workload since the corporation was established in 1974. Additional contractor work was in support of the increased workload in the areas of information technology and contractor personnel to handle the additional work with varying complexities. The Veteran's Employment and Training Administration (VETS) most notably saw increases associated with the addition of Transition Assistance Program (TAP) workshops conducted overseas. Finally, the Department reviewed its information technology systems to improve security and data integrity in compliance with Federal Information Security Management Act (FISMA) during this period.

Mr. Obey: Please update the information on page 532 of Part 7 of the Hearings on the FY 2008 President's request by providing a table including the number, dollar amount, and percentage of the total for all contracts awarded noncompetitively for each of the fiscal years 2000 through 2007. In addition, please provide an explanation for the growth in noncompetitive contracts.

Ms. Chao: The table below shows the total for all contracts awarded noncompetitively for each of the fiscal years 2000 through 2007.

The Department is committed to competitively awarding contracts whenever possible and is consistently ranked among the top agencies for competition. The Department's growth in noncompetitive contract obligations has been fairly stable across the five year period, starting at 15.5% in 2000 and ending at 15.7% for 2007. The number of non-competitive actions increased primarily due to the decrease in the reporting threshold in the Federal Procurement Data System, the system of record for Federal procurements, from \$25,000 to \$3,000.

CONTRACTING

Mr. Obey: Please provide a table including the total noncompetitive contract obligations for each operating division within the department and the share of such obligations for the department for each of the fiscal years 2000 through 2007.

Ms. Chao: The table below shows noncompetitive contract obligations for each operating division from years 2000 through 2007.

US Department of Labor Non-competitive Contracts Obligations for Each DOL Operating Division By Fiscal Year									
Agency	2000	2001	2002	2003	2004	2005	2006	2007	
BLS	1,833,000	2,345,000	1,439,000	15,378,683	31,340,102	152,952	1,118,372	5,315,240	
EBSA	2,397,000	2,848,000	3,965,000	2,294,171	17,009	254,712	1,796,124	1,215,419	
ESA	3,430,000	3,786,000	1,264,000	3,477,402	78,800	2,516,389	9,627,275	56,762,006	
ETA	15,621,000	16,036,000	32,194,000	18,663,446	11,634,607	17,692,383	27,613,656	16,748,078	
ILAB	1,283,000	7,902,000	1,502,000	276,000		254,825	194,607	3,241,909	
JobCorps	142,541,970	118,942,160	153,192,062	146,124,682	185,299,268	110,390,394	164,158,542	144,379,506	
MSHA	2,778,000	7,457,000	7,498,202	10,256,457	14,382,171	6,360,505	3,928,804	9,220,214	
ODEP	85,000	208,000	526,000	288,000			315,844	6,758,049	
OIG	80,000	35,000	280,000	0	1,403,425	301,713	1,941,747	2,425,823	
OSHA	3,111,000	3,761,000	5,571,000	2,581,635	1,539,014	3,321,848	7,965,606	10,477,716	
PBGC					83,000	161,669	177,155	1,175,266	
SOL	2,339,000	2,462,000	3,573,000	3,067,329		261,239	603,565	472,004	
VETS	2,491,000	1,312,000	1,005,000	753,500	1,600	331,507	2,047,881	2,434,913	
DM	22,024,000	20,554,000	56,424,145	22,135,800	5,189,862	7,481,535	24,730,556	42,894,630	
DOL Total	\$200,013,970	\$187,648,160	\$268,433,409	\$225,297,105	\$250,968,858	\$149,481,671	\$246,219,734	\$303,520,773	

The table below shows percentage share of non-competitive contracts obligations by agency from years 2000 through 2007.

US Department of Labor Percentage Share of Non-competitive Contracts Obligations for Each DOL Operating Division By Fiscal Year								
Agency	2000	2001	2002	2003	2004	2005	2006	2007
BLS	0.92%	1.25%	0.54%	6.83%	12.49%	0.10%	0.45%	1.75%
EBSA	1.20%	1.52%	1.48%	1.02%	0.01%	0.17%	0.73%	0.40%
ESA	1.71%	2.02%	0.47%	1.54%	0.03%	1.68%	3.91%	18.70%
ETA	7.81%	8.55%	11.99%	8.28%	4.64%	11.84%	11.22%	5.52%
ILAB	0.64%	4.21%	0.56%	0.12%	0.00%	0.17%	0.08%	1.07%
JobCorps	71.27%	63.39%	57.07%	64.86%	73.83%	73.85%	66.67%	47.57%
MSHA	1.39%	3.97%	2.79%	4.55%	5.73%	4.26%	1.60%	3.04%
ODEP	0.04%	0.11%	0.20%	0.13%	0.00%	0.00%	0.13%	2.23%
OIG	0.04%	0.02%	0.10%	0.00%	0.56%	0.20%	0.79%	0.80%
OSHA	1.56%	2.00%	2.08%	1.15%	0.61%	2.22%	3.24%	3.45%
PBGC	0.00%	0.00%	0.00%	0.00%	0.03%	0.11%	0.07%	0.39%
SOL	1.17%	1.31%	1.33%	1.36%	0.00%	0.17%	0.25%	0.16%
VETS	1.25%	0.70%	0.37%	0.33%	0.00%	0.22%	0.83%	0.80%
DM	11.01%	10.95%	21.02%	9.83%	2.07%	5.00%	10.04%	14.13%
DOL Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Changes for ESA are attributable to the award of a sole source extension to the Lockheed Martin contract for medical bill processing in the later part of FY 2006. It is one of the agency's largest contracts.

CONTRACTING

Mr. Obey: Please update and consolidate the tables on the page 533 of Part 7 of the Hearing of the FY 2008 President's request. Please provide a table with the number of contract actions and total awards for contracts issued with less than full and open competition by operating division, and for the department as a whole, in each of the fiscal years 2005, 2006 and 2007.

Ms. Chao: The table below shows the number of contract actions and total awards for contracts issued with less than full and open competition by operating division and for the department as a whole from fiscal year 2005 through 2007.

**Summary of Actions/Obligations
for Less Than Full and Open Competition Contracts**

Fiscal Year	Agency	Actions	Obligations
2005	BLS	36	152,952
	DM	327	7,481,535
	EBSA	51	16,473,618
	ESA	242	2,516,389
	ETA	369	17,692,383
	ILAB	7	254,825
	JobCorps	353	110,390,394
	MSHA	353	6,360,505
	OIG	23	301,713
	OSHA	335	3,321,848
	PBGC	3	161,669
	SOL	32	261,239
	VETS	15	331,507
2005 Total		2,146	165,700,577
2006	BLS	74	1,118,372
	DM	448	24,730,556
	EBSA	70	15,141,735
	ESA	233	9,627,275
	ETA	283	27,613,656
	ILAB	7	194,607
	JobCorps	312	164,158,542
	MSHA	382	3,928,804
	ODEP	3	315,844
	OIG	47	1,941,747
	OSHA	384	7,965,606
	PBGC	4	177,155
	SOL	36	603,565
	VETS	13	2,047,881
2006 Total		2,296	259,565,345
2007	BLS	134	5,315,240
	DM	672	42,894,630
	EBSA	81	14,935,027
	ESA	358	56,762,006
	ETA	437	16,748,078
	ILAB	16	3,241,909
	JobCorps	248	144,379,506
	MSHA	445	9,220,214
	ODEP	18	6,758,049
	OIG	39	2,425,823
	OSHA	667	10,477,716
	PBGC	21	1,175,266
	SOL	67	472,004
	VETS	15	2,434,913
2007 Total		3,218	317,240,381

The large BLS increase from 2005 to 2006, and then from 2006 to 2007 is attributable to a likely coding error under review. BLS has been aggressively increasing participation in the SBA 8(a) program, including the GSA Stars program in late 2005 and 2006, a large new contract with a Native American 8(a) firm in 2007, and other short term contracts supportive of the program which by statute is considered non-competitive. Further, while conducting competitive acquisitions, BLS has extended existing contracts on a sole source basis to provide limited coverage and system support until the competition was finalized. Lastly, BLS incurred a several million dollar increase in non-competitive acquisitions due to last year's protest of the competitive Data Collection contract, which required a non-competitive extension of the incumbent contractor while a competitive re-procurement action is completed. The ODEP increase is for a grant/cooperative agreement that was miscoded as a contract.

Also attached, is a table that depicts the contract actions by agency for fiscal year 2007.

HSEC 4

**U.S. Department of Labor
Detail Listing of Contracts with Less Than Full and Open Competition**

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
2007	BLS	FOLLOW ON TO COMPETED	DOLB072J11257	FREELANCE TECHNOLOGIES, INC	2,217
			DOLB072J11260	COMP CLEAN INC	9,872
			DOLB072J11292	REMCO BUSINESS SYSTEMS INC	975
			DOLB072J11506	WASHINGTON METROPOLITAN AREA TRANSI	79,416
			DOLB072J11569	PARASOFT CORPORATION	2,900
			DOLB072J11649	SPSS INC	6,000
			DOLB072J11759	VADOR VENTURES INC	3,025
			DOLB072J11861	SUPERWYLBUR SYSTEMS INC	7,825
			DOLB07FJ21156	SYMPHONY SERVICE CORP	526
			DOLB07FJ21301	HOLTZE MAGNOLIA, LLP	800
			DOLB07FJ21308	XEROX CORPORATION	258
			DOLB07FJ21309	XEROX CORPORATION	3,309
			DOLB07FJ21310	XEROX CORPORATION	312
			DOLB07FJ21311	MARK OF DISTINCTION INC	1,128
			DOLB07FJ21313	CUMMINS-ALLISON CORP	255
			DOLB07FJ21322	XEROX CORPORATION	7,941
			DOLB07FJ21324	CUSTOM CLEANING SERVICES	1,920
			DOLB07FJ21325	MATSUSHITA ELECTRIC CORPORATION OF	5,860
			DOLB07FJ21326	NEXTIRAONE FEDERAL, LLC	599
			DOLB07FJ21328	COMPUTATA PRODUCTS INC	3,693
			DOLB07FJ21334	XEROX CORPORATION	6,156
			DOLB07FJ21336	OCE NORTH AMERICA, INC	6,323
			DOLB07FJ21338	NEXTEL COMMUNICATIONS OF THE MID-AT	3,969
			DOLB07FJ21339	AVCORP BUSINESS SYSTEMS LLC	1,182
			DOLB07FJ21428	FEDSOURCE-BALTIMORE	756
			DOLB082J12076	CDW GOVERNMENT INC	0
			DOLU072J11421	LYME COMPUTER SYSTEMS, INC	3,302
			DOLU072J11452	LYME COMPUTER SYSTEMS, INC	5,006
			DOLU072J11733	DUN & BRADSTREET INC	71,415
			DOLU072J11863	LYME COMPUTER SYSTEMS, INC	36,236
			DOLU072J11962	FOUR POINTS TECHNOLOGY LLC	1,320
			DOLU072J11965	FOUR POINTS TECHNOLOGY LLC	1,902
			DOLU072J12083	G & B SOLUTIONS INC	148,117
			DOLU079J25631	BETIS GROUP, INC.	122,688
		NON-COMPETITIVE DELIVERY ORDER	DOLB059J22156	OMEGA TECHNOLOGIES, INC.	1,385,287
			DOLF072J11263	CANON U.S.A., INC	7,992
			DOLF072J11283	FCN INC	2,698
			DOLF072J11328	CDW GOVERNMENT INC	8,650
			DOLF072J11499	WESTAT, INC	24,800
			DOLF072J11681	IMMIXTECHNOLOGY INC	8,240
			DOLF072J11736	MARKET STRATEGIES INC	64,144
			DOLF072J11808	FIRST FEDERAL CORPORATION	21,467
			DOLF072J11809	EMTEC FEDERAL INCORPORATED	12,000
			DOLF072J11843	CDW GOVERNMENT INC	40,323
			DOLF072J11873	CONVERGENCE TECHNOLOGY CONSULTING L	24,000
			DOLF072J11875	MERLIN TECHNICAL SOLUTIONS INC	44,768
			DOLF072J11914	GARTNER, INC.	15,088
			DOLF072J11930	AQUILENT INCORPORATED	123,208
			DOLF07DJ21034	XEROX CORPORATION	3,260
			DOLF07DJ21035	XEROX CORPORATION	3,586
			DOLF07DJ21037	XEROX CORPORATION	6,037
			DOLF07DJ21038	XEROX CORPORATION	10,785
			DOLF07DJ21339	AVAYA INC. GOVERNMENT SOLUTION	19,848
			DOLF07EJ20851	OCE NORTH AMERICA, INC	8,253
			DOLF07EJ20926	NORTEL NETWORKS INC	10,800
			DOLF07EJ20994	XEROX CORPORATION	7,155
		NOT AVAILABLE FOR COMPETITION	DOLB072J11932	BARLING BAY LLC	6,587
			DOLB072J11936	CONSOLIDATED SAFETY SERVICES INCORP	48,629

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB072J11947	CPI SAGE ETH DENVER OPERATOR, LLC	1,512
			DOLB072J11956	BARLING BAY LLC	25,617
			DOLB072J11972	BARLING BAY LLC	373,096
			DOLB07FJ21312	COAST ELECTRIC POWER ASSN	1,500
			DOLU072J11338	ELECTRONIC DATA INTEGRATION CO	6,405
		NOT COMPETED	DOLB072J11430	SMITH, ELEANOR H	23,232
			DOLB072J11475	CANNON BUSINESS SOLUTIONS EAST	1,540
			DOLB072J11477	VADOR VENTURES INC.	3,751
			DOLB072J11639	MACROECONOMIC ADVISERS LLC	16,475
			DOLB072J11699	WASHINGTON METROPOLITAN AREA TRANSI	534,000
			DOLB072J11705	SMITH, ELEANOR H	44,693
			DOLB072J11722	NATIONAL BUREAU OF ECONOMIC RESEARC	10,000
			DOLB072J11762	PROQUEST INFORMATION AND LEARNING C	30,600
			DOLB072J11789	JOHNSON CONTROLS, INC	71,300
			DOLB072J11823	NATIONAL TECHNICAL INFORMATION SERV	23,895
			DOLB072J11829	KLEIN, DEBORAH	16,000
			DOLB072J11885	VADOR VENTURES INC	17,311
			DOLB072J11887	UNIVERSITY OF MARYLAND	25,000
			DOLB072J11888	Ball, Robert F.	15,000
			DOLB072J11900	CONRAD, FREDERICK G	15,000
			DOLB072J11944	JOHNSON CONTROLS, INC	28,576
			DOLB072J11945	JONES-YEATMAN, WANDA	2,000
			DOLB072J11946	XYENTERPRISE INC.	18,810
			DOLB072J12006	CHANG, THEODORE	25,000
			DOLB07EJ20870	FAXBACK INC	1,221
			DOLB07EJ20872	RICOH BUSINESS SYSTEMS	582
			DOLB07EJ20930	CUMMINS-ALLISON CORP	327
			DOLB07EJ21020	CANON BUSINESS SOLUTIONS-CENTRAL, I	961
			DOLB07EJ21047	CANON BUSINESS SOLUTIONS-CENTRAL, I	526
			DOLB07EJ21056	CANNON BUSINESS SOLUTIONS EAST	378
			DOLB07EJ21060	GORDON FLESH COMPANY INC	1,016
			DOLB07EJ21078	IKON OFFICE SOLUTIONS	392
			DOLB07FJ21159	NEXTEL COMMUNICATIONS OF THE MID-AT	920
			DOLB07GJ20279	SCOTT RICE KANSAS CITY INC	81,345
			DOLU079J24862	EXECUTIVE INFORMATION SYSTEMS,	703,219
		NOT COMPETED UNDER SIMP ACQ PROC	DOLB072J11427	SABRE INC	540
			DOLB072J12029	R S MEANS COMPANY INC	23,200
			DOLB07AJ20372	ABC MOVING SERVICES INC	400
			DOLB07AJ20376	VARICK STREET PARKING	1,284
			DOLB07AJ20377	BACK BAY NEWS DISTRIBUTORS INC	780
			DOLB07AJ20419	TAC CENTRE INC	650
			DOLB07BJ20514	SAN DIEGO HOTEL LEASE LLC	2,019
			DOLB07FJ21327	LODGING OPPORTUNITIES CORP	9,265
			DOLB07FJ21393	IMAGETEK OFFICE SYSTEMS, L.P.	600
			DOLB07FJ21397	CESCO COIN EQUIPMENT SERVICE COMPAN	491
			DOLJ079J26117	BARLING BAY LIMITED LIABILITY COMPA	700,000
	DM	FOLLOW ON TO COMPETED	DOLB069624305	BITLAND, INC.	204,924
			DOLB06F421141	WCCT	3,000
			DOLB079426218	MOBILE VIDEO SERVICES LTD	44,000
			DOLB079426225	OPPIX AND HIDER INCORPORATED	57,991
			DOLB079426231	OPPIX AND HIDER INCORPORATED	40,000
			DOLB079426237	HISPANIC ASSOCIATION OF COLLEGES &	12,900
			DOLB079624915	PROJECT PERFORMANCE CORPORATION	772,212
			DOLB079625414	FEAC INSTITUTE, INC	42,000
			DOLB079625527	HISPANIC ASSOCIATION OF COLLEGES &	10,397
			DOLB079626470	MERLIN TECHNICAL SOLUTIONS INC	432,050
			DOLB079626562	OPPIX AND HIDER INCORPORATED	30,008
			DOLB079626566	OPPIX AND HIDER INCORPORATED	50,012
			DOLB07D620994	MUZAK LLC	5,496
			DOLB07F421063	IRON MOUNTAIN INFORMATION MANAGEMEN	34,504

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07F621231	FORCE 3 INC	2,279
		DOLB07F621232	LRP PUBLICATIONS INC	2,238
		DOLB07F621236	T-MOBILE USA, INC.	364
		DOLB07F621240	CINGULAR WIRELESS, LLC	6,272
		DOLB07F621242	OCE NORTH AMERICA, INC	59,688
		DOLB07F621243	UNITED PARCEL SERVICE	16,167
		DOLB07F621249	CONTRACT CONSULTANTS INC	7,616
		DOLB07F621251	SOUTHWESTERN BELL TELEPHONE, L.P.	540
		DOLB07F621256	CUMMINS-ALLISON CORP	263
		DOLB07F621287	TRANSWESTERN INVESTMENT COMPANY, L.	6,050
		DOLB07F621298	MARK OF DISTINCTION INC	398
		DOLB07F621321	SIMPLEXGRINNELL LP	141
		DOLB07F621323	OCE NORTH AMERICA, INC	6,306
		DOLB07F621344	SIMPLEX TIME RECORDER CO.	132
		DOLB07H420199	CELLCO PARTNERSHIP DBA VERIZON WIRE	984
		DOLB07H420208	WOMEN ENTREPRENEURS INC	41,000
		DOLB07H420223	FEDSOURCE-BALTIMORE	1,310
		DOLB07H420224	FEDSOURCE-BALTIMORE	4,429
		DOLB07H420228	FEDSOURCE-BALTIMORE	2,469
		DOLJ079625348	Jori Maron	229,240
		DOLJ079625357	B.I.G. ENTERPRISES, INC.	181,488
		DOLU069423885	DATATAC INFORMATION SERVICES,	10,000
		DOLU069623637	USER TECHNOLOGY ASSOCIATES, IN	239,859
		DOLU079425320	GRAFIK INDUSTRIES, LTD	0
		DOLU079425326	CONCEPTS INCORPORATED	349,000
		DOLU079426017	EVENT STRATEGIES INC	323,688
		DOLU079426408	USER TECHNOLOGY ASSOCIATES, IN	1,289,889
		DOLU079426501	ELITE INFORMATION SYSTEMS, INC	15,600
		DOLU079624195	USER TECHNOLOGY ASSOCIATES, IN	2,720,872
		DOLU079624609	USER TECHNOLOGY ASSOCIATES, IN	1,606,159
		DOLU079624621	TATC CONSULTING CORPORATION	255,192
		DOLU079624700	USER TECHNOLOGY ASSOCIATES, IN	64,818
		DOLU079624749	USER TECHNOLOGY ASSOCIATES, IN	67,329
		DOLU079624817	F Y I FOR YOUR INFORMATION INC	366,224
		DOLU079624826	F Y I FOR YOUR INFORMATION INC	78,884
		DOLU079625007	MONSTER GOVERNMENT SOLUTIONS	372,412
		DOLU079625016	BOOZ ALLEN HAMILTON INC.	1,200,000
		DOLU079625019	TATC CONSULTING CORPORATION	112,251
		DOLU079625084	THE HR SOURCE	302,400
		DOLU079625145	THE HR SOURCE	128,404
		DOLU079625188	F Y I FOR YOUR INFORMATION INC	157,780
		DOLU079625196	F Y I FOR YOUR INFORMATION INC	41,020
		DOLU079625207	F Y I FOR YOUR INFORMATION INC	94,674
		DOLU079625266	USER TECHNOLOGY ASSOCIATES, IN	999,988
		DOLU079625351	NETSTAR-1 INC	53,237
		DOLU079625711	KEYLOGIC SYSTEMS INC	728,059
		DOLU079625829	EASTERN RESEARCH GROUP, INC.	399,992
		DOLU079625832	AQUILENT INCORPORATED	173,565
		DOLU079625842	EASTERN RESEARCH GROUP, INC.	288,938
		DOLU079625865	EASTERN RESEARCH GROUP, INC.	289,249
		DOLU079625866	EASTERN RESEARCH GROUP, INC.	49,995
		DOLU079625838	THE HR SOURCE	39,360
		DOLU079625861	SYSTEMS RESEARCH AND APPLICATI	269,955
		DOLU079625862	ICF INCORPORATED, L.L.C.	269,846
		DOLU079625863	ICF INCORPORATED, L.L.C.	384,155
		DOLU079626054	ICF INCORPORATED, L.L.C.	289,851
		DOLU079626337	MATHEMATICA POLICY RESEARCH IN	399,428
		DOLU07J20352	NETSTAR-1 INC	13,737
	NON-COMPETITIVE DELIVERY ORDER	DOLB079424860	MOBILE VIDEO SERVICES LTD	5,500
		DOLB079424870	ATTILIS & ASSOCIATES	40,978
		DOLB079424900	OPPIX AND HIDER INCORPORATED	73,500
		DOLB079425464	PRODUCTION LINK LIMITED LIABILITY C	43,000

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB079425638	POWERTRAIN INCORPORATED (2689)	50,003
		DOLB079624117	STRATOS ELEVATOR, INC.	229,656
		DOLB079625031	INTERNATIONAL BUSINESS MACHINES COR	55,458
		DOLB07F421146	XEROX CORPORATION	7,978
		DOLF041A00002	MCNEELY PIGOTT & FOX PUBLIC RE	240,000
		DOLF069623255	NETSTAR-1 INC	372,857
		DOLF069623839	COMPUTAS NA, INC.	1,216,665
		DOLF069624286	MYTHICS, INC	65,100
		DOLF079424397	XEROX CORPORATION	24,535
		DOLF079424399	XEROX CORPORATION	3,545
		DOLF079424731	CINGULAR WIRELESS LLC	2,512
		DOLF079424783	MATTHEW BENDER & CO INC.	4,838
		DOLF079424791	CINGULAR WIRELESS LLC	12,500
		DOLF079425033	REED ELSEVIER, INC.	37,080
		DOLF079425119	CANON U.S.A., INC	10,625
		DOLF079425436	CASCADES TECHNOLOGIES INC	1,240,150
		DOLF079425622	SOFTCHOICE CORPORATION	6,857
		DOLF079425671	DLT SOLUTIONS INCORPORATED	6,825
		DOLF079425834	SPECTRUM SYSTEMS, INC.	79,832
		DOLF079425969	XEROX CORPORATION	13,535
		DOLF079426159	CINGULAR WIRELESS LLC	6,821
		DOLF079426304	ESCGOV	10,000
		DOLF079624225	XEROX CORPORATION	45,907
		DOLF079624227	XEROX CORPORATION	220,851
		DOLF079624494	THE BUREAU OF NATIONAL AFFAIRS	461,200
		DOLF079624570	AVAYA INC. GOVERNMENT SOLUTION	352,432
		DOLF079624662	XEROX CORPORATION	3,321
		DOLF079624663	XEROX CORPORATION	2,064
		DOLF079624669	CINGULAR WIRELESS LLC	4,596
		DOLF079624829	MANAGEMENT CONCEPTS INC	22,453
		DOLF079624871	MANAGEMENT CONCEPTS INC	15,052
		DOLF079625014	MANAGEMENT CONCEPTS INC	22,802
		DOLF079625056	DISTRIBUTED SOLUTIONS, INC	990,883
		DOLF079625115	ERGONETICS LLC	19,657
		DOLF079625229	EBSCO INDUSTRIES, INC	36,190
		DOLF079625253	GTSI CORP	18,644
		DOLF079625325	SYBASE, INC.	5,809
		DOLF079625408	ALLSTEEL INC	29,968
		DOLF079625459	SYBASE, INC.	21,559
		DOLF079625521	ROWE FRONT INC	0
		DOLF079625582	XEROX CORPORATION	17,976
		DOLF079625616	ROWE FRONT INC	10,190
		DOLF079625702	RICOH CORPORATION	9,029
		DOLF079625743	RICHARD S CARSON AND ASSOCIATES INC	121,385
		DOLF079625923	DANKA HOLDING COMPANY	132,530
		DOLF079626195	AMERICAN SCIENCE AND ENGINEERI	769,470
		DOLF079626421	ELLISON SYSTEMS, INC	75,188
		DOLF079626571	FOUR POINTS TECHNOLOGY LLC	88,395
		DOLF079626585	STRATOS MOBILE NETWORKS, INC.	20,562
		DOLF07C120841	XEROX CORPORATION	7,469
		DOLF07C320813	OCE NORTH AMERICA, INC	5,776
		DOLF07C321000	OCE NORTH AMERICA, INC	9,369
		DOLF07C421004	XEROX CORPORATION	8,564
		DOLF07C620875	AVAYA INC. GOVERNMENT SOLUTION	38,973
		DOLF07C621016	CELLCO PARTNERSHIP DBA VERIZON WIRE	4,857
		DOLF07CA20863	XEROX CORPORATION	679
		DOLF07CA20876	OCE NORTH AMERICA, INC	9,752
		DOLF07CA20970	XEROX CORPORATION	3,982
		DOLF07CA21072	XEROX CORPORATION	2,812
		DOLF07CA21074	KNOLL, INC	3,678
		DOLF07CE20877	XEROX CORPORATION	5,937
		DOLF07CE20932	XEROX CORPORATION	3,936
		DOLF07CE21051	XEROX CORPORATION	4,080

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLF07CF20913	XEROX CORPORATION	2,375
		DOLF07CF20943	NEOPOST INC.	2,252
		DOLF07CF20976	XEROX CORPORATION	5,280
		DOLF07CF20977	XEROX CORPORATION	2,121
		DOLF07CF20989	XEROX CORPORATION	12,075
		DOLF07CF21003	XEROX CORPORATION	4,080
		DOLF07CF21006	XEROX CORPORATION	800
		DOLF07CF21035	XEROX CORPORATION	3,625
		DOLF07CF21050	EXPONENT INCORPORATED	3,000
		DOLF07CJ20925	KONICA MINOLTA BUSINESS SOLUTI	10,108
		DOLF07CJ20927	KONICA MINOLTA BUSINESS SOLUTI	4,172
		DOLF07CJ20928	CANON U.S.A., INC	7,800
		DOLF07CJ20929	CANON U.S.A., INC	5,495
		DOLF07CN20893	XEROX CORPORATION	5,479
		DOLF07CN20899	WEST PUBLISHING CORPORATION	14,931
		DOLF07CN20973	MATTHEW BENDER & CO INC.	3,693
		DOLF07CN21002	XEROX CORPORATION	16,882
		DOLF07D420870	INTELLIGENT DECISIONS, INC	40,841
		DOLF07D420887	CELLCO PARTNERSHIP DBA VERIZON WIRE	74,500
		DOLF07D620997	CINGULAR WIRELESS LLC	9,953
		DOLF07D621155	XEROX CORPORATION	2,778
		DOLF07D621305	XEROX CORPORATION	2,701
		DOLF07D621332	DISTRIBUTED SOLUTIONS, INC	10,161
		DOLF07D621333	AQUILENT INCORPORATED	5,715
		DOLF07DE20995	OCE NORTH AMERICA, INC	7,001
		DOLF07E420742	XEROX CORPORATION	8,679
		DOLF07E420743	XEROX CORPORATION	7,926
		DOLF07E420825	MATTHEW BENDER & CO INC.	3,492
		DOLF07E420953	XEROX CORPORATION	9,652
		DOLF07E620738	J B CUBED, INC	59,744
		DOLF07E620869	L R P PUBLICATIONS INC	2,984
		DOLF07E621023	ANSLEY BUSINESS MATERIALS OF C	1,128
		DOLF07F621288	CONTRACT CONSULTANTS INC	49,504
		DOLF07J620205	USER TECHNOLOGY ASSOCIATES, IN	312,626
		DOLF07J620324	STEELCASE INC	30,323
		DOLU069423646	THORPE INTERNATIONAL, INC	14,309
	NOT AVAILABLE FOR COMPETITION	DOLB069424526	FEMCO, INC	63,325
		DOLB069622315	AMERICAN PEST MANAGEMENT INC	0
		DOLB079424766	WYCLIFFE ENTERPRISES, INC	168,965
		DOLB079424891	COUNTERTRADE PRODUCTS, INC.	6,972
		DOLB079424918	PANAMERICA COMPUTERS INC	4,993
		DOLB079425026	LEADERSHIP DIRECTORIES INC	3,910
		DOLB079425199	CAPITOL CREAG, LLC	36,796
		DOLB079425296	BACON'S INFORMATION INC	10,045
		DOLB079425649	GLOBAL INSIGHT, INC.	20,370
		DOLB079425759	THE COLEMAN GROUP INC	72,831
		DOLB079425828	2020 COMPANY, LLC	93,688
		DOLB079426063	PANAMERICA COMPUTERS, INC	7,481
		DOLB079426095	WYCLIFFE ENTERPRISES, INC	9,269
		DOLB079426411	COUNTERTRADE PRODUCTS, INC.	12,383
		DOLB079624557	PRATICO, LYNNE MARIE	9,518
		DOLB079624690	CONGRESSIONAL QUARTERLY, INC	22,000
		DOLB079624725	FEMCO INC	8,352
		DOLB079624755	ENSPER TECHNOLOGIES INC	252,550
		DOLB079624782	COMMUNICATIONS PROFESSIONALS	7,938
		DOLB079624888	COUNTERTRADE PRODUCTS, INC.	12,953
		DOLB079624978	MERLIN INTERNATIONAL, INC	104,050
		DOLB079625051	BITLAND, INC.	35,200
		DOLB079625285	QUEST DIAGNOSTICS INCORPORATED	5,550
		DOLB079625415	THE PERARA GROUP INC	35,600
		DOLB079625525	B I G ENTERPRISES, INC	24,480
		DOLB079625705	TURNKEY SECURITY INC	69,925

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB079625727	YANCY & ASSOCIATES INC	48,431
		DOLB079625816	GOLD COAST CONSULTING, INC	109,855
		DOLB079625847	TELECOMMUNICATION SOLUTIONS GROUP,	44,633
		DOLB079625896	PANAMERICA COMPUTERS INC	13,272
		DOLB079625908	TMI SOLUTIONS INCORPORATED	361,240
		DOLB079625973	FRONT ROWE, INC.	14,290
		DOLB079626185	AMERICAN SCIENCE AND ENGINEERING, I	51,750
		DOLB079626252	DRT STRATEGIES INC	149,792
		DOLB079626321	THE COLEMAN GROUP INC	110,584
		DOLB079626327	FOUR POINTS TECHNOLOGY LLC	48,395
		DOLB079626328	COUNTERTRADE PRODUCTS, INC.	10,460
		DOLB079626430	THREATGUARD, INC	9,972
		DOLB079626594	B.I.G. ENTERPRISES, INC.	165,750
		DOLB079626598	B.I.G. ENTERPRISES, INC.	360,000
		DOLB07D620889	BOWE BELL & HOWELL COMPANY	10,319
		DOLB079620171	W2007 SEATTLE OFFICE 1111 THIRD AVE	368
		DOLB079425649	GLOBAL INSIGHT INCORPORATED	20,370
		DOLB079625722	AMERICAN EAGLE PROTECTIVE SERVICES	201,149
		DOLB079625724	TRIBAL CO, LLC	986,255
		DOLQ049610745	CW GOVERNMENT TRAVEL INCORPORATED	300,000
		DOLU069424009	COMTER SYSTEMS, INC	1,403,467
		DOLU079624788	PROCUREVIS INC	236,214
		DOLU079625218	PROCUREVIS INC	154,414
	NOT COMPETED	DOLB06D420920	CONSUMER CREDIT COUNSELING SERVICE	0
		DOLB06H420196	ALFUT MANAGEMENT SERVICES, LLC.	12,024
		DOLB079423953	SYSTEMS PLUS INCORPORATED	157,843
		DOLB079424850	COUNTERTRADE PRODUCTS, INC.	34,351
		DOLB079424894	FEMCO, INC	34,689
		DOLB079425010	NATIONAL JOURNAL GROUP, INC	3,899
		DOLB079425018	POWERTRAIN INCORPORATED (2689)	50,000
		DOLB079425226	KNOWLEDGE INFORMATION SOLUTIONS, IN	8,268
		DOLB079425255	ZEPHYR DEVELOPMENT CORPORATION	17,500
		DOLB079425429	MYTHICS, INC	24,391
		DOLB079425642	HAVER ANALYTICS INC	52,495
		DOLB079425689	JURIS PUBLISHING INC	3,540
		DOLB079425970	CONGRESSIONAL QUARTERLY INC	3,099
		DOLB079426220	Women Work the National Network for	468,000
		DOLB079623972	GLOBAL TECH INC	394,099
		DOLB079624523	SALVATORE ARRIGO	9,518
		DOLB079624537	FRANKLIN, BARBARA B	9,518
		DOLB079624539	STEPHEN E ALPERN ARBITRATOR	9,518
		DOLB079624541	HOCHHAUSER, LOIS LAW OFFICES	9,518
		DOLB079624551	SEAN J ROGERS & ASSOCIATES, LLC	9,518
		DOLB079624554	GLOBALMEDARB LLC	9,518
		DOLB079624610	PROGRESSIVE TECHNOLOGY FEDERAL SYST	23,402
		DOLB079624636	FEDERAL EMPLOYEE EDUCATION AND ASSI	68,040
		DOLB079624667	MERLIN TECHNICAL SOLUTIONS INC	79,440
		DOLB079624670	CANON U.S.A., INC	4,096
		DOLB079624671	AMERITEL COMMUNICATIONS CORPORATION	3,315
		DOLB079624692	NEW MEDIA LEARNING, LLC	4,995
		DOLB079624744	POSTEDIGITAL LLC	8,930
		DOLB079624747	NW SYSTEMS, INC	826,435
		DOLB079624767	U S BUSINESS INTERIORS, INC	8,240
		DOLB079624771	FEMCO, INC	55,935
		DOLB079624932	APPTIS INC	117,159
		DOLB079624935	XOSOFT, INC	43,000
		DOLB079624939	DEROSA/MANGOLD CONSULTING INC	2,720
		DOLB079624940	WHITE SANDS TECHNOLOGY, INC	16,128
		DOLB079625013	PANAMERICA COMPUTERS INC	11,045
		DOLB079625024	DENSEL CO	4,320
		DOLB079625042	B.I.G. ENTERPRISES, INC.	148,000
		DOLB079625087	PEMBROOK OCCUPATIONAL HEALTH, INC	16,561

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB079625090	WAGNER RESOURCES INC	97,993
		DOLB079625114	NCS PEARSON INC	13,953
		DOLB079625149	EMBARCADERO TECHNOLOGIES, INC	21,039
		DOLB079625216	WAGNER RESOURCES INC	80,000
		DOLB079625257	UNITED STATES POSTAL SERVICE	3,800
		DOLB079625410	PANAMERICA COMPUTERS INCORPORATED	438,195
		DOLB07A420339	MATTHEW BENDER & COMPANY INC	3,058
		DOLB07A420467	MASSACHUSETTS COMMISSION ON THE STA	2,500
		DOLB07B420411	CRANFORD, TOWNSHIP OF	3,600
		DOLB07B420412	WEST PUBLISHING CORPORATION	3,057
		DOLB07C421086	HEALTHY CAREGIVER COMMUNITY FOUNDAT	2,000
		DOLB07C421100	HEALTHY CAREGIVER COMMUNITY FOUNDAT	3,000
		DOLB07C421102	KOREAN COMMUNITY SERVICE CENTER	3,000
		DOLB07C421189	PENNSYLVANIA WOMEN WORK	3,000
		DOLB07C620797	LEISURE FITNESS INC	672
		DOLB07C620871	NEW CINGULAR WIRELESS SERVICES, INC	6,000
		DOLB07C620895	SMITHS DETECTION - WARREN, INC.	4,500
		DOLB07C620910	PROGRAM SUPPORT CENTER	121,039
		DOLB07C621064	MANAGEMENT AND TRAINING CORPORATION	2,000
		DOLB07CA20800	CURTIS PARTNERS, LP	1,000
		DOLB07CA20955	PITNEY BOWES INC	16,548
		DOLB07CA20962	PITNEY BOWES INC	2,700
		DOLB07CE20785	CANON U.S.A., INC	2,612
		DOLB07CE20819	KONICA MINOLTA BUSINESS SOLUTIONS U	887
		DOLB07CE20833	MID-ATLANTIC CASU V	2,066
		DOLB07CE20836	KONICA MINOLTA BUSINESS SOLUTIONS U	2,992
		DOLB07CE20851	RICOH CORPORATION	4,356
		DOLB07CE20891	RICOH CORPORATION	8,299
		DOLB07CE20979	GRAND PLAZA RESORTS INC	6,378
		DOLB07CE20988	CANON U.S.A., INC	830
		DOLB07CE21018	RICOH CORPORATION	4,356
		DOLB07CE21019	RICOH CORPORATION	4,356
		DOLB07CE21042	BLAIR COMMUNICATIONS, INCORPORATED	3,624
		DOLB07CE21059	STANDARD DIGITAL IMAGING, INC.	750
		DOLB07CE21079	ROADWAY EXPRESS INC	4,063
		DOLB07CE21080	ROADWAY EXPRESS INC	3,500
		DOLB07CE21092	DOMINON TELEPHONE INC	6,805
		DOLB07CF20878	ARCH WIRELESS HOLDINGS, INC.	3,128
		DOLB07CF20880	OCE NORTH AMERICA, INC	10,141
		DOLB07CF20881	XEROX CORPORATION	2,296
		DOLB07CF20892	ARCH WIRELESS OPERATING COMPANY	3,000
		DOLB07CF20911	THOMSON SCIENTIFIC INC	4,600
		DOLB07CF20948	DOCUMENT AUTOMATION & PRODUCTION SE	4,830
		DOLB07CF21049	STABLER ASSOCIATES INC	12,000
		DOLB07CF21075	AKF REPORTERS INC	2,200
		DOLB07CF21081	AEGIS CORP	2,400
		DOLB07CF21090	WANGER CONSULTING	5,625
		DOLB07CJ20996	NEXTEL COMMUNICATIONS OF THE MID-AT	4,500
		DOLB07CN20898	CCH INC	4,726
		DOLB07CN20900	WEST PUBLISHING CORPORATION	1,964
		DOLB07CN20905	CCH INC	4,726
		DOLB07CN21011	P & W CONSULTING GROUP, INC	1,653
		DOLB07D421345	YWCA OF GREATER ATLANTA	20,000
		DOLB07E420928	UNITED PARCEL SERVICE, INC.	4,000
		DOLB07E420938	CENTRAL PARKING SYSTEM	3,360
		DOLB07E421114	UNIVERSITY OF MICHIGAN	1,500
		DOLB07E421129	NETWORKING TOGETHER INC.	1,000
		DOLB07E421139	BRASS RING PRODUCTIONS LTD	2,000
		DOLB07E421140	WOMENS BUSINESS DEVELOPMENT CENTER	10,000
		DOLB07E421161	ASIAN AMERICAN ALLIANCE	0
		DOLB07E421175	WISCONSIN WOMENS COUNCIL	2,000
		DOLB07E421176	THE TRANSITION NETWORK	2,000
		DOLB07E421183	WOMENVENTURE	5,000

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07E421184	Y W C A OF METROPOLITAN CHICAGO	3,000
		DOLB07E421190	UNIVERSITY OF ILLINOIS AT CHICAGO	20,000
		DOLB07E421192	COLLEGE OF DUPAGE	5,000
		DOLB07E421204	NEW WORLD CONNECTIONS, INC	10,000
		DOLB07E421212	ANGELINA LAYCOCK	7,000
		DOLB07E421215	DOLLARS AND SENSE INC.	1,000
		DOLB07E421231	CAMBODIAN ASSOCIATION OF ILLINOIS I	1,000
		DOLB07E421256	COMMUNITY FINANCIAL EDUCATION INC	3,000
		DOLB07E421258	INDIANA COMMISSION FOR WOMEN	3,000
		DOLB07E421259	CHICAGO FEDERAL EXECUTIVE BOARD	12,000
		DOLB07E421260	ASIAN AMERICAN INSTITUTE	3,000
		DOLB07E620864	CANON BUSINESS SOLUTIONS-CENTRAL I	428
		DOLB07E621072	LASALLE REPORTING SERVICE LTD	2,365
		DOLB07E621088	VIKING LABOR SERVICES	2,640
		DOLB07E621172	MERLIN DICKHANS	300
		DOLB07E621245	UAW PAT GREATHOUSE EDUCATIONAL CENT	4,600
		DOLB07EF21189	MUJERES LATINAS EN ACCION	3,000
		DOLB07F421004	NW SYSTEMS, INC.	350
		DOLB07F421443	JOHNSON, ROBIN	10,000
		DOLB07F421447	ODYSSEY HOUSE LOUISIANA, INC	20,000
		DOLB07F421450	TEXAS COOPERATIVE EXTENSION	65,000
		DOLB07F421610	CATALYST STRATEGY GROUP INC	15,000
		DOLB07F621007	ROBERT STEPHENSON	8,500
		DOLB07F621382	DAVID J DUGAS	2,536
		DOLB07F621487	NATIONAL BUSINESS FURNITURE	2,348
		DOLB07F621488	NATIONAL BUSINESS FURNITURE	9,295
		DOLB07F621633	ARTOPEX-PLUS INC	3,616
		DOLB07G420212	PANASONIC DOCUMENT IMAGING COMPANY	2,229
		DOLB07G420221	PANASONIC DOCUMENT IMAGING COMPANY	872
		DOLB07G420243	SPACES, INC	1,112
		DOLB07G420254	HR SYSTEMS INC	3,000
		DOLB07G420255	KUSTER LTD	1,500
		DOLB07G420260	HREDGE SOLUTIONS	4,500
		DOLB07G420283	HUMAN RIGHTS, IOWA DEPARTMENT OF	500
		DOLB07G420285	CONNECTIONS TO SUCCESS	1,000
		DOLB07G420286	UNIV OF MISSOURI-KC WOMENS CENTER	500
		DOLB07G420287	KANSAS CITY KANSAS COMMUNITY COLLEG	1,500
		DOLB07G420288	LINCOLN-LANCASTER WOMEN'S	1,500
		DOLB07G420289	LINCOLN-LANCASTER WOMEN'S	500
		DOLB07G420290	CONNECTIONS TO SUCCESS	20,000
		DOLB07G420296	FEDERAL EXECUTIVE BOARD	1,600
		DOLB07G420298	YWCA OF GREATER KANSAS CITY INC	6,500
		DOLB07G420299	A WOMANS LIFETIME FINANCIAL FORUM	500
		DOLB07G420300	HR SYSTEMS INC	3,000
		DOLB07G420301	HREDGE SOLUTIONS	2,500
		DOLB07G420302	EMPOWERMENT CONSULTING INC	5,600
		DOLB07G420303	HUMAN RIGHTS, IOWA DEPARTMENT OF	4,000
		DOLB07G420305	FEDERAL EXECUTIVE BOARD	1,000
		DOLB07G620220	PANASONIC DOCUMENT IMAGING COMPANY	2,229
		DOLB07G620244	STEELCASE INC	3,447
		DOLB07G620246	BROWN, LOUIS M.	132
		DOLB07G620250	BROWN, LOUIS M.	264
		DOLB07G620252	COPAKEN WHITE BLITT LLC	550
		DOLB07G620253	FEDERAL OCCUPATIONAL HEALTH	2,799
		DOLB07G620282	BROWN, LOUIS M.	132
		DOLB07G620268	BROWN, LOUIS M.	83
		DOLB07G620273	BROWN, LOUIS M.	1,271
		DOLB07G620276	BROWN, LOUIS M.	132
		DOLB07G620277	CROSS TELECOM CORPORATION	98,815
		DOLB07G620278	CROSS TELECOM CORPORATION	15,429
		DOLB07G620291	CR8, INC	4,205
		DOLB07G620296	WHELAN SECURITY CO.	3,994
		DOLB07G620297	BROWN, LOUIS M.	132

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07G620306	KANSAS CITY AUDIO VISUAL, INC.	7,684
		DOLB07GF20240	GRAY, PATRICIA A	400
		DOLB07H420220	WOMEN ENTREPRENEURS INC	35,000
		DOLB07H420222	ROUNDTREE CONSULTING	25,000
		DOLB07H420225	CAREER TRAINING INSTITUTE INC	15,000
		DOLB07H420226	CAREER TRANSITIONS, INC	15,000
		DOLB07H420227	TOP LADIES OF DISTINCTION	2,300
		DOLB07H420242	DANIELS COLLEGE OF BUSINESS	2,000
		DOLB07H420243	TRUE LIGHT BAPTIST CHURCH	1,500
		DOLB07H420257	COLORADO COALITION FOR THE HOMELESS	2,000
		DOLB07H420258	COLORADO SPRINGS ALUMNAE CHAPTER OF	500
		DOLB07H420260	XEROX CORPORATION	350
		DOLB07H420261	NORTH DAKOTA WOMEN'S NETWORK	4,500
		DOLB07H420263	MACEDONIA BAPTIST CHURCH	1,500
		DOLB07H420264	DENVER REGIONAL COUNCIL OF GOVERNME	3,500
		DOLB07H420265	JEFFERSON COUNTY SCHOOL DISTRICT R-	1,500
		DOLB07H420266	DENVER DELTA INC	2,000
		DOLB07H420270	CRAWFORD WILLIAMS GROUP, LLC, THE	12,000
		DOLB07J420320	TKC INTEGRATION SERVICES LLC	5,192
		DOLB07J420327	EMERALD SUN	5,500
		DOLB07J420350	WOMENS BUSINESS CENTER OF CALI	2,500
		DOLB07J420356	MY SERVICE MIND OF NORTH WEST	10,000
		DOLB07J420358	SAN DIEGO ASSOCIATION OF GOVERNMENT	4,000
		DOLB07J420359	CHANDLER CHAMBER OF COMMERCE	3,000
		DOLB07J420360	MOMS IN BUSINESS ENTERPRISES	3,000
		DOLB07J420397	FORESIGHT MANAGEMENT	4,000
		DOLB07J620280	CUSHMAN & WAKEFIELD OF CALIFORNIA I	3,000
		DOLB07J620309	SHARP	9,284
		DOLB07J620337	CLUBCARE INC	395
		DOLB07KX20148	D.I.A.L. PRO NORTHWEST, INC.	5,119
		DOLJ069423906	CASCADES TECHNOLOGIES INC	2,356,192
		DOLJ069624220	VIGNETTE PUBLIC SECTOR & EDUCATION	36,989
		DOLJ069624426	WASHINGTON METROPOLITAN AREA TRANSI	2,472,900
		DOLJ069624534	BANK BLDG LTD PRTNESHIP	105,196
		DOLJ079624835	LOUIS & HENRY, INC.	245,742
		DOLJ079624836	ANN E PHARR	71,652
		DOLJ079625388	B.I.G. ENTERPRISES, INC.	21,600
		DOLJ079625492	ABN TECHNOLOGIES LLC	1,099,617
		DOLU069624004	SAVANTAGE FINANCIAL SERVICES,	252,036
		DOLU079624330	B.I.G. ENTERPRISES, INC.	339,732
		DOLU079624962	SAVANTAGE FINANCIAL SERVICES,	356,921
	NOT COMPETED UNDER SIMP ACQ PROC	DOLB079425028	CONGRESSIONAL QUARTERLY INC	2,549
		DOLB079426558	INNOVATIVE TECHNOLOGIES INC	3,042
		DOLB079625096	SYBASE, INC.	1,905
		DOLB07A420341	NORTHERN BUSINESS MACHINES	648
		DOLB07A420402	CENTRAL VT COMMUNITY ACTION COUNCIL	2,450
		DOLB07A420438	BOSTON COLLEGE, TRUSTEES OF	500
		DOLB07A420444	MONEY MANAGEMENT INTERNATIONAL, INC	1,000
		DOLB07A420445	MAINE WOMEN'S POLICY CENTER	1,000
		DOLB07A420449	RHODE ISLAND COMMISSION ON WOMEN	2,500
		DOLB07A620326	PITNEY BOWES INC	1,673
		DOLB07A620327	PITNEY BOWES INC	1,583
		DOLB07A620387	GOVERNMENT RETIREMENT & BENEFITS, I	1,960
		DOLB07A620421	DONNEGAN SYSTEMS INC	1,860
		DOLB07A620426	SHANER HOTEL GROUP L.P.	2,365
		DOLB07A620479	REGIONAL EMERGENCY MEDICAL SERVICE	1,200
		DOLB07A620489	BCH DATA SYSTEM MANAGEMENT	800
		DOLB07A20416	MONEY MANAGEMENT INTERNATIONAL, INC	500
		DOLB07B420563	MASIELLO, MICHAEL A & ASSOCIATES	2,400
		DOLB07B420565	YOUNG WOMEN'S CHRISTIAN ASSOCIATION	2,000
		DOLB07B420566	HELICON INC	250

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB07B420596	SUFFOLK COUNTY COMMUNITY COLLEGE	2,000
			DOLB07B420598	CORNELL COOPERATIVE EXTENSION ULSTE	2,000
			DOLB07B420600	CENTER FOR THE WOMEN OF NEW YORK	500
			DOLB07B420605	PARENTJOBNET INC	2,400
			DOLB07B420606	JEWISH FAMILY & VOCATIONAL SERVICE	2,400
			DOLB07D421329	NATIONAL ASSOCIATION OF COMMISSIONS	5,000
			DOLB07F421281	MUZAK LLC	1,224
			DOLB07F421434	HOPE CENTER, THE	2,000
			DOLB07F421439	SER SANTA FE JOBS FOR PROGRESS, INC	3,000
			DOLB07F421550	FORD, MARJORIE WILSON	3,000
			DOLB07F621385	NATIONAL BUSINESS FURNITURE	586
			DOLB07F621402	SASS, JOHN F	2,900
			DOLB07H420217	DENVER REGIONAL COUNCIL OF GOVERNME	1,000
			DOLJ079626236	DRT STRATEGIES,INC	150,000
	EBSA	FOLLOW ON TO COMPETED	DOLB06F321165	OCE NORTH AMERICA, INC	2,602
			DOLB07D321011	BELLSOUTH BUSINESS SYSTEMS, INC	12,900
			DOLB07D321162	PACER SERVICE CENTER	2,000
			DOLB07F321403	XEROX CORPORATION	7,563
			DOLB07F321530	OCE NORTH AMERICA, INC	7,985
			DOLB07F321532	NOVACOPY INC	1,404
			DOLB07F321533	SUMNER GROUP INC.	660
			DOLB07F321549	XEROX CORPORATION	7,455
			DOLU069623855	TESSADA & ASSOCIATES, INC.	118,877
			DOLU069623856	TESSADA & ASSOCIATES, INC.	276,133
		NON-COMPETITIVE DELIVERY ORDER	DOLF079324769	EXECUTIVE INFORMATION SYSTEMS,	16,125
			DOLF079325349	DUN & BRADSTREET INC	4,179
			DOLF079325359	NETPRO COMPUTING, INC.	5,694
			DOLF079326009	LEXISNEXIS SPECIAL SERVICES INC.	49,286
			DOLF07E320874	RICOH CORPORATION	1,284
			DOLF07E320982	CANON U.S.A., INC	5,669
		NOT AVAILABLE FOR COMPETITION			
			DOLB079325068	FTI CONSULTING INC	28,470
			DOLB079325069	JAMS LLC	6,256
			DOLB079325171	BVA LLC	6,000
			DOLB079325335	FTI CONSULTING INC	91,056
			DOLB079325444	FERRELL CONSULTING INC	0
			DOLB079325831	TKC INTEGRATION SERVICES LLC	30,873
			DOLB079326050	RESEARCH INSTITUTE OF AMERICA	42,074
			DOLB079326168	ACE PRODUCTS LLC	9,164
			DOLB07J320239	SBC GLOBAL SERVICES, INC	7,008
			DOLJ059322372	COMMUNICATIONS RESOURCE, INC.	41,278
			DOLB079324719	RGM BENEFITS CONSULTING CO.	12,000
			DOLB079325060	GREATER BOISE AUDITORIUM DISTRICT	4,550
			DOLB079325134	ALIXPARTNERS LLC	150,000
			DOLB079325137	BROME, GLENN	10,390
			DOLB079325139	HOLIDAY PACIFIC PARTNERS LTD PTR	10,768
			DOLB079325175	ASHFORD TRS LESSEE LL LLC	3,628
			DOLB079325209	NATIONAL JOURNAL GROUP, INC	3,898
			DOLB079325284	CAMBRIDGE ADVISORY GROUP INC	10,000
			DOLB079325352	CORE-SDI INC	22,750
			DOLB079325378	LEFOLDT & COMPANY	2,868
			DOLB079325432	ELBAOR, DAVID	3,500
			DOLB079325528	LEFOLDT & COMPANY	2,962
			DOLB079325672	VALUEKNOWLEDGE LLC	36,000
			DOLB079325706	HAY GROUP INC	20,095
			DOLB079325795	NAVIGANT CONSULTING, INC	0
			DOLB079325984	THE BUREAU OF NATIONAL AFFAIRS INC	13,622
			DOLB079325990	STRATALYTICS	19,500
			DOLB079326002	CAMBRIDGE ADVISORY GROUP INC	5,000
			DOLB079326014	WALLACE DELURY & O'NEIL INC CPA	18,000
		NOT COMPETED			

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB079326018	ANDREW MINTZER	15,625
		DOLB079326028	ALIXPARTNERS LLC	0
		DOLB079326098	SAINT CORPORATION	9,958
		DOLB079326151	ACME FILING CONCEPTS INC	4,161
		DOLB07E320863	CANON BUSINESS SOLUTIONS-CENTRAL, I	325
		DOLB07E320885	KASTLE SYSTEMS	4,956
		DOLB07E320886	IKON OFFICE SYSTEMS	9,502
		DOLB07E320887	IKON OFFICE SYSTEMS	751
		DOLB07E320932	IKON OFFICE SOLUTIONS	480
		DOLB07E320933	IKON OFFICE SOLUTIONS	1,040
		DOLB07E320960	RADISSON HOTEL CINCINNATI RIVERFRON	1,200
		DOLB07E321104	UPS FREIGHT	1,054
		DOLB07E321116	INFINITE SERVICES CONTRACTING CORP	2,248
		DOLB07E321167	UPS FREIGHT	182
		DOLB07E321414	OFFICE EQUIPMENT COMPANY	6,317
		DOLB07G320201	KYOCERA MITA AMERICA, INC.	3,513
		DOLB07G320209	IMAGISTICS INTERNATIONAL INC	2,340
		DOLB07G320265	WROC INC	1,125
		DOLB07G320280	ZELLMER ASSOCIATES INC	11,364
		DOLB07G320294	CARARYAN ENTERPRISES, INC.	410
		DOLB07G320304	IKON OFFICE SOLUTIONS	1,733
		DOLB07J320238	STORAGE PERFORMANCE COUNCIL	5,607
		J9P80037	NCS PEARSON, INC.	13,719,608
	NOT COMPETED UNDER SIMP ACQ PROC	DOLB07A320369	XEROX CORPORATION	312
		DOLB07B320491	MEDTRONIC PHYSIO-CONTROL GROUP	1,070
	ESA	FOLLOW ON TO COMPETED		
		DOLB069E23045	PARAGON TECHNICAL SERVICES INCORPOR	125,950
		DOLB07D321044	PACER SERVICE CENTER	0
		DOLB07D321049	PACER SERVICE CENTER	500
		DOLB07FA21218	PITNEY BOWES INC	6,075
		DOLB07FE21066	SPRINT COMMUNICATIONS COMPANY L.P.	3,968
		DOLB07FE21150	QWEST CORPORATION	1,565
		DOLB07FE21151	SOUTHWESTERN BELL TELEPHONE, L.P.	860
		DOLB07FE21154	SOUTHWESTERN BELL TELEPHONE, L.P.	250
		DOLB07FE21183	DANKA OFFICE IMAGING COMPANY	1,514
		DOLB07FE21226	OCE NORTH AMERICA, INC	3,361
		DOLB07FE21227	XEROX CORPORATION	5,185
		DOLB07FE21244	XEROX CORPORATION	7,812
		DOLB07FE21271	CONTRACT CONSULTANTS INC	57,513
		DOLB07FE21273	COMPUTATA PRODUCTS INC	2,600
		DOLB07FE21274	CORPORATE EXPRESS	2,600
		DOLB07FE21286	SOUTHWESTERN BELL TELEPHONE LIMITED	200
		DOLB07FE21291	XEROX CORPORATION	10,077
		DOLB07FE21296	PANASONIC CORPORATION OF NORTH AMER	1,082
		DOLB07FE21299	ALAMO TROPHIES	252
		DOLB07FE21342	PTS OFFICE SYSTEM, INC	1,077
		DOLB07FE21346	FRED L LAKE & CO, INC	2,500
		DOLB07FE21358	SOUTHWEST COPY SYSTEMS INC	1,374
		DOLB07FE21400	RICOH CORPORATION	1,225
		DOLB07FE21411	HAWORTH, INC	9,629
		DOLB07FE21417	FREEMAN U-STORIT INS	1,560
		DOLB07FE21418	SUMNER GROUP INC	198
		DOLB07FE21419	SUMNER GROUP INC	198
		DOLB07FE21420	SUMNER GROUP INC	1,393
		DOLB07FE21426	FEDSOURCE-BALTIMORE	21,779
		DOLB07FE21484	PITNEY BOWES INC	528
		DOLB07FE21497	RICOH CORPORATION	552
		DOLB07FE21498	IKON OFFICE SOLUTIONS, INC.	1,056
		DOLB07FE21506	IKON OFFICE SOLUTIONS, INC.	1,042
		DOLB07FE21507	CANON USA, INC	2,391
		DOLB07FE21604	OCE FINANCIAL SERVICES INC	2,460

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB07FE21609	OCE FINANCIAL SERVICES INC	948
			DOLB07FE21615	OCE NORTH AMERICA, INC	12,550
			DOLB07HE20198	CASU DENVER	13,762
			DOLB07HE20207	TREASURY FRANCHISE FUND, US	4,608
			DOLB07KE20170	PGP VALUATION	17,760
			DOLU079425837	DELL MARKETING LIMITED PARTNERSHIP	77,830
			DOLU079E25470	PROCUREVIS INC	55,860
			DOLU079E26550	PARAGON TECHNICAL SERVICES, INC.	8,223,275
		NON-COMPETITIVE DELIVERY ORDER	DOLB079E24656	CINGULAR WIRELESS LLC	667
			DOLB079E25219	PANACEA CONSULTING INC	70,700
			DOLB079E26291	GOVCONNECTION INCORPORATED	67,359
			DOLB0FE20752	OCE NORTH AMERICA, INC	7,589
			DOLF05DE21231	OFFICE DEPOT, INC.	19,154
			DOLF069E24031	THE EFX COMPANY	7,624
			DOLF079E24360	XEROX CORPORATION	5,240
			DOLF079E24371	XEROX CORPORATION	6,229
			DOLF079E24374	XEROX CORPORATION	3,129
			DOLF079E24378	XEROX CORPORATION	24,276
			DOLF079E24390	XEROX CORPORATION	299
			DOLF079E24394	XEROX CORPORATION	974
			DOLF079E24462	XEROX CORPORATION	47,379
			DOLF079E24580	CINGULAR WIRELESS LLC	14,487
			DOLF079E24704	REED ELSEVIER, INC.	15,300
			DOLF079E24819	BOOZ ALLEN HAMILTON INC.	1,476,060
			DOLF079E24857	VERITAS SOFTWARE CORPORATION	7,454
			DOLF079E24948	EC AMERICA, INC	25,452
			DOLF079E24959	EXECUTIVE INFORMATION SYSTEMS,	24,097
			DOLF079E24996	HAWORTH, INCORPORATED	5,139
			DOLF079E25041	COMSTOR CORPORATION	16,062
			DOLF079E25102	DUN & BRADSTREET INC	21,336
			DOLF079E25260	DELL MARKETING LIMITED PARTNERSHIP	12,850
			DOLF079E25338	DELL MARKETING LIMITED PARTNERSHIP	47,504
			DOLF079E25918	INTERNATIONAL BUSINESS MACHINE	92,057
			DOLF079E26000	PROGRAMMER'S PARADISE, INC.	25,622
			DOLF079E26138	DUN & BRADSTREET INC	27,343
			DOLF079E26226	ALLIANCE TECHNOLOGY GROUP LLC	74,730
			DOLF07DE20903	XEROX CORPORATION	9,185
			DOLF07DE20995	OCE NORTH AMERICA, INC	2,220
			DOLF07DE21007	OCE NORTH AMERICA, INC	11,613
			DOLF07E620738	J B CUBED, INC	15,000
			DOLF07EE20854	OCE NORTH AMERICA, INC	4,471
			DOLF07EE20855	OCE NORTH AMERICA, INC	4,704
			DOLF07EE20856	OCE NORTH AMERICA, INC	8,377
			DOLF07EE20879	OCE NORTH AMERICA, INC	8,566
			DOLF07EE20882	ANSLEY BUSINESS MATERIALS OF C	1,009
			DOLF07EE20886	ANSLEY BUSINESS MATERIALS OF C	823
			DOLF07EE20917	KONICA MINOLTA BUSINESS SOLUTI	3,130
			DOLF07EE20919	RICOH CORPORATION	1,854
			DOLF07EE20920	OCE NORTH AMERICA, INC	5,419
			DOLF07EE20924	RICOH CORPORATION	1,764
			DOLF07EE20979	ANSLEY BUSINESS MATERIALS OF C	225
			DOLF07EE20980	XEROX CORPORATION	312
			DOLF07EE20981	ANSLEY BUSINESS MATERIALS OF C	1,675
			DOLF07EE21001	ANSLEY BUSINESS MATERIALS OF C	953
			DOLF07EE21012	ANSLEY BUSINESS MATERIALS OF C	1,632
			DOLF07EE21028	ANSLEY BUSINESS MATERIALS OF C	1,009
			DOLF07EE21050	HAWORTH, INCORPORATED	41,253
			DOLF07EE21075	ANSLEY BUSINESS MATERIALS OF C	1,031
			DOLF07EE21099	ANSLEY BUSINESS MATERIALS OF C	222
			DOLF07EE21120	ANSLEY BUSINESS MATERIALS OF C	1,009
			DOLF07EE21159	ANSLEY BUSINESS MATERIALS OF C	422
			DOLF07EE21160	ANSLEY BUSINESS MATERIALS OF C	202

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLF07EE21197	ANSLEY BUSINESS MATERIALS OF C	222
		DOLF07EE21255	ANSLEY BUSINESS MATERIALS OF C	222
		DOLF07EE21257	KNOLL, INC.	5,169
		DOLF07FE21259	XEROX CORPORATION	6,120
		DOLF07FE21277	NATIONAL BUSINESS FURNITURE, LLC	50,850
		DOLF07FE21337	PITNEY BOWES INC	10,125
		DOLF07KE20135	RICOH CORPORATION	5,822
		DOLF07KE20152	RICOH CORPORATION	2,600
		DOLF07FE20753	OCE NORTH AMERICA, INC	7,425
		DOLU069E22620	DATATRAC INFORMATION SERVICES,	50,000
		DOLU079E24977	LOCKHEED MARTIN SERVICES INC	325,455
	NOT AVAILABLE FOR COMPETITION	DOLB069E22646	THE PERARA GROUP INCORPORATED	5,000
		DOLB079E24411	PANAMERICA COMPUTERS INC	8,797
		DOLB079E24612	PANAMERICA COMPUTERS INC	7,028
		DOLB079E24681	RADIUS TECHNOLOGY GROUP INC	90,786
		DOLB079E24816	FEMCO, INC	16,573
		DOLB079E24844	RADIUS TECHNOLOGY GROUP INC	100,328
		DOLB079E24886	SOFTECH, INC	85,363
		DOLB079E24917	COUNTERTRADE PRODUCTS, INC.	101,225
		DOLB079E25011	SOFTECH, INC	221,184
		DOLB079E25040	COUNTERTRADE PRODUCTS, INC.	8,990
		DOLB079E25046	COUNTERTRADE PRODUCTS, INC.	82,217
		DOLB079E25091	VERAMARK TECHNOLOGIES, INC.	11,061
		DOLB079E25098	COUNTERTRADE PRODUCTS, INC.	15,795
		DOLB079E25157	COUNTERTRADE PRODUCTS, INC.	65,681
		DOLB079E25159	PANAMERICA COMPUTERS INC	4,649
		DOLB079E25167	GLOBAL TECH INC	93,000
		DOLB079E25437	Eugene Muller	20,000
		DOLB079E25565	FEMCO, INC	8,278
		DOLB079E26334	TOTAL CONTRACTING INC	6,500
		DOLB07KE20163	CDW GOVERNMENT INC	11,340
		DOLB07KE20164	MC MILLAN ELECTRIC	5,195
		DOLJ069E24212	ASRC MANAGEMENT SERVICES, INC	10,687,442
		DOLJ079E24786	ASRC MANAGEMENT SERVICES, INC	393,286
		DOLJ079E25293	GLOBAL TECH INC	561,758
		DOLU079E26472	EASTERN RESEARCH GROUP, INC.	99,800
	NOT COMPETED	DOLB069E24698	OCE NORTH AMERICA, INC	7,330
		DOLB079E24472	INFORMATION FOR PUBLIC AFFAIRS, INC	10,800
		DOLB079E24656	CINGULAR WIRELESS, LLC	3,338
		DOLB079E24716	MARK A FIEN	8,250
		DOLB079E24818	AGSI, LLC	5,216
		DOLB079E24890	RADIUS TECHNOLOGY GROUP INC	67,949
		DOLB079E24999	INTERNATIONAL BUSINESS MACHINES COR	96,834
		DOLB079E25023	CENTER TO PROTECT WORKERS RIGHTS IN	628,130
		DOLB079E25109	Test Review Services	20,000
		DOLB079E25390	FEMCO, INC	4,235
		DOLB079E25411	DOCUMENT SYSTEMS, INCORPORATED	7,868
		DOLB079E25507	MILLIMAN INC	4,625
		DOLB079E25664	Patricia M. Wood	24,883
		DOLB079E25729	BUREAU OF NATIONAL AFFAIRS, INC., T	20,200
		DOLB079E25731	QUALITY CASUALTY CONSULTING, L P	37,000
		DOLB079E25732	QUALITY CASUALTY CONSULTING, L P	48,000
		DOLB079E25770	INTRINSYC SOFTWARE INTERNATIONAL, IN	7,605
		DOLB079E25780	Virginia I. Miller	24,900
		DOLB079E25868	SSB TECHNOLOGIES, INC.	10,455
		DOLB079E25999	ASSET OPTIMA LLC	16,542
		DOLB079E26069	TOTAL CONTRACTING INC	17,323
		DOLB079E26090	STERLING COMMERCE AMERICA, INC	10,000
		DOLB079E26181	DLT SOLUTIONS, INC.	11,270
		DOLB079E26189	WANDA J CAMPBELL & ASSOCIATES	20,000
		DOLB079E26245	UNIFIED TELDATA, INC	23,723

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB079E26302	ELSEVIER INC.	24,950
		DOLB079E26317	UNIVERSITY OF PENNSYLVANIA INC	14,280
		DOLB079E26455	OXFORD OBG-WATERTON SKOKIE HOTEL PR	13,631
		DOLB07DE21127	SHELDONSINRICH LLC	80,200
		DOLB07DE21346	BARRETT, BRUCE	4,550
		DOLB07EE20770	PINETREE PERIPHERALS INC	3,375
		DOLB07EE20773	AMERICOMP IMAGING SOLUTIONS	3,760
		DOLB07EE20774	ELSEVIER INC	24,950
		DOLB07EE20882	INTERPARKING INCORPORATED	14,460
		DOLB07EE20884	KEGLERS INC	540
		DOLB07EE20921	AMERICAN COPY EQUIPMENT	5,600
		DOLB07EE20951	UPS FREIGHT	122
		DOLB07EE20955	DONNELLON MCCARTHY INC.	2,160
		DOLB07EE20965	STANDARD PARKING	1,200
		DOLB07EE20967	GRAND RAPIDS PARKING SERVICES	1,409
		DOLB07EE20987	CENTRAL PARKING SYSTEMS	824
		DOLB07EE20999	UPS FREIGHT	248
		DOLB07EE21003	CUMMINS-ALLISON CORP.	380
		DOLB07EE21004	CUMMINS-ALLISON CORP.	380
		DOLB07EE21005	CUMMINS-ALLISON CORP.	380
		DOLB07EE21019	CENTRAL PARKING SYSTEM	840
		DOLB07EE21024	UPS FREIGHT	183
		DOLB07EE21036	UPS FREIGHT	111
		DOLB07EE21108	RESORT AT PORT ARROWHEAD	750
		DOLB07EE21109	XANTERRA PARKS & RESORTS INC	1,500
		DOLB07EE21112	STONE CREEK INN OF LACROSSE	580
		DOLB07EE21113	RESIDENCE INN CENTERPOINT	340
		DOLB07EE21157	UPS FREIGHT	125
		DOLB07EE21158	UPS FREIGHT	125
		DOLB07EE21168	GRAND GENEVA HOTEL	200
		DOLB07EE21180	COURTYARD BY MARRIOTT OHARE	600
		DOLB07FE120871	DANKA HOLDING COMPANY PARENT COMPAN	417
		DOLB07FE21262	CELLCO PARTNERSHIP DBA VERIZON WIRE	5,500
		DOLB07FE21263	UNIVERSITY OF TEXAS AT SAN ANTONIO	1,265
		DOLB07FE21347	OAG WORLDWIDE INC	478
		DOLB07FE21348	OAG WORLDWIDE INC	459
		DOLB07FE21349	MIDWEST TROPHY MFG CO INC	2,500
		DOLB07FE21423	SPSS INC	7,085
		DOLB07FE21436	KORMAN COMMUNITIES	4,850
		DOLB07FE21445	NATIONAL BUSINESS FURNITURE	22,359
		DOLB07GA20225	IKON FINANCIAL SERVICES	1,140
		DOLB07GA20226	IKON FINANCIAL SERVICES	1,140
		DOLB07GA20227	IKON FINANCIAL SERVICES	1,140
		DOLB07GE20198	PANASONIC DOCUMENT IMAGING COMPANY	2,229
		DOLB07GE20199	PANASONIC DOCUMENT IMAGING COMPANY	1,401
		DOLB07GE20208	PANASONIC DOCUMENT IMAGING COMPANY	2,700
		DOLB07GE20213	IKON FINANCIAL SERVICES	5,640
		DOLB07GE20214	PANASONIC DOCUMENT IMAGING COMPANY	2,229
		DOLB07GE20215	PANASONIC DOCUMENT IMAGING COMPANY	2,229
		DOLB07GE20228	PANASONIC DOCUMENT IMAGING COMPANY	4,458
		DOLB07GE20238	SUPERIOR MOVING SERVICE INC	4,644
		DOLB07GE20242	THE GUNLOCK COMPANY L.L.C.	24,955
		DOLB07GE20263	CONTRACT FURNISHINGS, INC.	4,860
		DOLB07JE20357	ATLAS HOTELS, INC.	1,493
		DOLB07KE20111	MATTHEW BENDER & COMPANY INC	3,757
		DOLB07KE20123	PITNEY BOWES INC.	15,232
		DOLB07KE20126	SBC	8,400
		DOLB07KE20127	QWEST	4,951
		DOLB07KE20137	PITNEY BOWES INC	6,885
		DOLB07KE20155	PHOENIX HOTEL ASSOCIATES, LTD, A CA	8,035
		DOLJ069E24172	NATIONAL SYSTEMS RESOURCES	266,700
		DOLJ069E24614	ACS FEDERAL HEALTH CARE LLC	30,674,517
		DOLU079E26197	USER TECHNOLOGY ASSOCIATES, IN	99,826

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
		NOT COMPETED UNDER SIMP ACQ PROC			
			DOLB079E25932	BENNET COMMUNICATIONS INC	19,664
			DOLB079E25967	MULLEN, MARY ANN	24,500
			DOLB07AE20342	LAZ PARKING, LTD	900
			DOLB07AE20343	PITNEY BOWES INC	273
			DOLB07AE20345	IMAGISTICS INTERNATIONAL INC	324
			DOLB07AE20346	POWER DISTRIBUTION INC	1,960
			DOLB07AE20347	CUMMINS-ALLISON CORP	640
			DOLB07AE20348	PITNEY BOWES INC	234
			DOLB07AE20349	PITNEY BOWES INC	234
			DOLB07AE20350	PITNEY BOWES INC	234
			DOLB07AE20351	PITNEY BOWES INC	248
			DOLB07AE20352	IKON OFFICE SOLUTIONS	418
			DOLB07AE20353	PITNEY BOWES INC	248
			DOLB07AE20354	PITNEY BOWES INC	692
			DOLB07AE20356	PITNEY BOWES INC	256
			DOLB07AE20358	PITNEY BOWES INC	224
			DOLB07AE20359	PITNEY BOWES INC	209
			DOLB07AE20386	CHERRY HILL HOTEL MANAGEMENT LLC	380
			DOLB07AE20398	TAB PRODUCTS CO.	2,482
			DOLB07AE20415	VILLAS BY THE SEA OWNERS ASSOCIATIO	1,568
			DOLB07AE20420	W2005 WYN HOTELS L P	2,575
			DOLB07AE20452	VILLAS BY THE SEA OWNERS ASSOCIATIO	1,568
			DOLB07BE20419	PITNEY BOWES INC	99
			DOLB07BE20420	CENTRAL COPIER SERVICE, INC	795
			DOLB07BE20425	LOPRESTI, ANTHONY	2,310
			DOLB07BE20427	PITNEY BOWES INC	265
			DOLB07BE20428	PITNEY BOWES INC	100
			DOLB07BE20429	PITNEY BOWES INC	100
			DOLB07BE20430	CENTRAL TECHNOLOGY INC	630
			DOLB07BE20431	PITNEY BOWES INC	100
			DOLB07BE20432	PITNEY BOWES INC	100
			DOLB07BE20435	LOPRESTI, ANTHONY	160
			DOLB07BE20439	CENTRAL TECHNOLOGY INC	2,400
			DOLB07BE20440	DATA COMM CONSULTING GROUP, INC.	316
			DOLB07BE20497	SEA RESEARCH FOUNDATION INC	1,800
			DOLB07BE20528	MARCIA GOTLER	550
			DOLB07BE20541	SMITHSONIAN INSTITUTION	2,370
			DOLB07BE20559	BALLY'S PARK PLACE INC	795
			DOLB07BE20564	ALBANY MID TOWN HOTEL LLC	2,476
			DOLB07BE20581	TAB PRODUCTS CO.	1,472
			DOLB07BE20583	UNICOR FEDERAL PRISON INDUSTRIES IN	2,345
			DOLB07DE20890	AMERICOMP IMAGING SOLUTIONS	5,253
			DOLB07FE21223	INTERSTATE HOTELS & RESORTS INC	4,458
			DOLB07FE21374	MOLINA, TERRI B	2,000
			DOLB07FE21391	THE HON COMPANY	1,385
			DOLB07FE21404	SMG	1,917
			DOLB07FE21408	UNIVERSITY OF NEW ORLEANS RESEARCH	3,860
			DOLB07FE21437	POYDRAS LODGING INVESTMENT LTD PART	450
			DOLB07FE21440	PATTON CONTRACTORS, INC	2,326
			DOLB07FE21449	FEDERAL EMPLOYEES NEWS DIGEST INC	97
			DOLB07FE21451	COMPUTATA PRODUCTS INC	2,500
			DOLB07FE21452	OCE NORTH AMERICA, INC	8,272
			DOLB07FE21599	TAYLOR ASSOCIATES	2,100
			DOLB07HE20219	MULTIMEDIA AUDIO-VISUAL INC	400
			DOLB07JE20328	STEWART COMMUNICATIONS ASSOCIATES I	4,000
	ETA	FOLLOW ON TO COMPETED	DOLB061A20065	Mary Beth Hanner	2,400
			DOLB061A20295	JONES, EFFIE	2,400
			DOLB061A20297	KENYON, ROBERT S	2,100
			DOLB061A20298	LINARES, LORRAINE G	5,400

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB061A20299	MACCHIONI, PATRICIA	2,400
		DOLB061A20300	Mary Kuss	2,400
		DOLB07DA20932	TRC STAFFING SERVICES INC	43,000
		DOLB07DA20990	BELL SOUTH TELECOMMUNICATIONS INC.	7,504
		DOLB07FA21037	DANKA OFFICE IMAGING COMPANY	1,412
		DOLB07FA21160	OCE NORTH AMERICA, INC	2,100
		DOLB07FA21216	OCE NORTH AMERICA, INC	2,552
		DOLB07FA21284	SOUTHWESTERN BELL TELEPHONE, L.P.	4,000
		DOLB07FA21290	SOUTHWESTERN BELL TELEPHONE, L.P.	3,900
		DOLB07FA21293	BMI SYSTEMS CORPORATION	840
		DOLB07FA21295	BEST BUSINESS PRODUCTS INC	375
		DOLB07FA21302	PROGRAM SUPPORT CENTER	2,749
		DOLB07FA21303	PROGRAM SUPPORT CENTER	4,764
		DOLB07FA21304	PROGRAM SUPPORT CENTER	3,147
		DOLB07FA21305	PROGRAM SUPPORT CENTER	3,165
		DOLB07FA21307	CANON U.S.A., INC	1,859
		DOLB07FA21314	CANON U.S.A., INC	1,859
		DOLB07FA21317	KELLY SERVICES, INC.	49,125
		DOLB07FA21332	DANKA OFFICE IMAGING COMPANY	2,045
		DOLB07FA21345	CAPCO SYSTEMS	840
		DOLB07FA21424	FEDSOURCE-BALTIMORE	1,582
		DOLB07FA21425	FEDSOURCE-BALTIMORE	472
		DOLB07FA21446	FEDSOURCE-BALTIMORE	1,580
		DOLJ061A20207	COFFEY COMMUNICATIONS LLC	690,988
	NON-COMPETITIVE DELIVERY ORDER	DOLF041A00002	MCNEELY PIGOTT & FOX PUBLIC RE	630,000
		DOLF051A20038	HUNTER RICE PC	50,000
		DOLF071A20494	R. NAVARRO & ASSOCIATES, CPA'S	250,000
		DOLF07DA20928	CANON U.S.A., INC	4,373
		DOLF07DA20929	XEROX CORPORATION	8,665
		DOLF07EA20744	XEROX CORPORATION	79,250
		DOLF07EA20852	OCE NORTH AMERICA, INC	59,760
		DOLF07EA20983	CANON U.S.A., INC	16,075
		DOLF07EA20984	CANON U.S.A., INC	4,159
	NOT AVAILABLE FOR COMPETITION			
		DOLB041A00033	PAUL BENNETT	3,000
		DOLB041A00036	Ron Ludin	12,800
		DOLB041A00045	Nancy Beckley	7,200
		DOLB041A00047	Janice E. Perry	8,100
		DOLB051A20102	BACHEMIN, BEVERLY M	10,500
		DOLB051A20219	HARLOW, MICHAEL	2,400
		DOLB051A20223	NOLAN, GAIL Z	4,800
		DOLB061A20304	HENRY, JAMI	2,400
		DOLB071A20535	CHOMA, ZENOWIA	4,200
		DOLF051A20072	COBB, OLIVER F & ASSOCIATES LLC	589,000
		DOLJ061A20413	ANCON GROUP, LLC	403,331
		DOLJ061A20430	CREATIVE EYE INC, THE	148,954
		DOLJ071A20531	RESULTS TECHNOLOGIES SOLUTIONS INC	488,438
	NOT COMPETED	AF129850000330	COFFEY COMMUNICATIONS, LLC	19,518
		AS127980000340	STRATEGIC STAFFING, INC.	41,786
		AS134610000340	STRATEGIC STAFFING, INC.	437,700
		DOL061RP20083	MACRO Z TECHNOLOGY COMPANY	16,300
		DOLB041A00037	Charles Walker	8,100
		DOLB041A00040	Nicholas Jougras	2,400
		DOLB041A00050	COTTRELL CLAYTON	7,200
		DOLB041A00057	Rolf Dammann	7,800
		DOLB041A00059	Joseph Tayman	5,100
		DOLB041A00071	Katherine Wojcik	5,400
		DOLB041A00074	BAYLOR, CONCHITA	2,400
		DOLB041A00075	Diane Laws	2,400
		DOLB041A100047	PERRY, JANICE E	6,900
		DOLB041A10029	Robert McCurdy	900

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB041A10032	Karen Marshall	3,000
		DOLB051A20000	Andra P. REbar	14,000
		DOLB051A20052	Charlotte adams	1,500
		DOLB051A20053HYMANA	HYMAN, ALICE	10,800
		DOLB051A20074	BAKER SUSAN D.	10,200
		DOLB051A20075	BAYLIS-POWELL, SUSAN	2,400
		DOLB051A20079	KOCH, GEORGE	3,000
		DOLB051A20087	CARROLL, PATRICIA A	13,200
		DOLB051A20110	KELLEY-CUSEY, REBECCA	5,100
		DOLB051A20114	BURCHELL, JOAN T	12,000
		DOLB051A20133	BUFORD, CHERYL	8,100
		DOLB051A20134	CARTER, TAKISHA J	16,200
		DOLB051A20135	BEALE, GRANT	10,500
		DOLB051A20137	JOHNSON, SANDRA Y	8,400
		DOLB051A20139	HICKEY, KAREN	7,500
		DOLB051A20144	HILMER-CAPECE, JENNIFER	5,400
		DOLB051A20201	MARTIN, JEANETTE	2,400
		DOLB051A20216	MCCONNELL, WENDY L	7,200
		DOLB051A20218	HINES, AUTIE	2,400
		DOLB051A20227	JANUSIK, LAURA A	3,000
		DOLB051A20237	RANDI BLUMENTHAL-GUIGUI	5,100
		DOLB051A20239	BURKITT, DANIEL	4,500
		DOLB051A20240	CALVERIC, KAREN	10,500
		DOLB051A20241	COLEMAN, ALISON	4,800
		DOLB051A20243	SPARKS, JAMAL I	2,400
		DOLB051A20247	MJC & ASSOCIATES	2,400
		DOLB051A20252	LARISCH, ERICH W	2,400
		DOLB051A20255	MODIANO, CHARLES	2,400
		DOLB051A20257	BEERMAN, MARTHA E	10,800
		DOLB061A20261	SAUNDERS, KAY A	2,400
		DOLB061A20263	SIMON, JOEL	900
		DOLB061A20268	ALLEN, MARY C	3,000
		DOLB061A20270	WRIGHT, DAVID R	2,400
		DOLB061A20272	COHEN, ELAINE G	4,800
		DOLB061A20280	FREDERIC, M C	300
		DOLB061A20283	Stephanie Gutierrez	2,400
		DOLB061A20285	COBB, LORRAINE	2,400
		DOLB061A20289	BREWSTER, BEN	2,400
		DOLB061A20302	DUET, DANIEL	8,100
		DOLB061A20308	ERHARD, PATRICIA D	7,500
		DOLB061A20382	ANDERSON, JOAN F	3,000
		DOLB061A20384	BOYER, DONNA K	2,400
		DOLB061A20386	CARTWRIGHT, ANN P	7,200
		DOLB061A20389	Gary Anders	2,400
		DOLB061A20409	GOVERNMENT MICRO RESOURCES INC	20,953
		DOLB071A20436	Lynn L. Fletcher	5,400
		DOLB071A20441	CARROLL, PATRICIA A	3,000
		DOLB071A20442	JOUGRAS, NICHOLAS	7,800
		DOLB071A20443	DAVID DWULIT	3,000
		DOLB071A20445	Latonya Latamore	2,400
		DOLB071A20446	Margaret Mack	2,400
		DOLB071A20449	Dave Dwulit	4,500
		DOLB071A20450	CRAWFORD, CHERYLE	2,400
		DOLB071A20453	PARKER, ALYSON Z	2,400
		DOLB071A20455	Jennifer Pirtle	2,400
		DOLB071A20457	Sophonya Simpson	2,400
		DOLB071A20459	Jeffrey Weber	2,400
		DOLB071A20461	DS GRIFFEN & ASSOCIATES, INC.	32,746
		DOLB071A20462	LEVALLEY, JAMES F.	2,400
		DOLB071A20464	Mary Moorhouse	2,400
		DOLB071A20465	Shariene Henley	9,600
		DOLB071A20466	Joseph A. Hines	8,100
		DOLB071A20467	Maria M. Houser	2,400

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB071A20468	Phyllis R. Hutto	2,400
		DOLB071A20471	Marguerite Teleford	2,400
		DOLB071A20472	LAFLIN, KIRK J.	2,400
		DOLB071A20473	Juline Albert	2,400
		DOLB071A20474	COTTRELL, CLAYTON	6,600
		DOLB071A20475	Russ Hamm	2,400
		DOLB071A20479	Elaine Gaertner	5,100
		DOLB071A20480	GARRETT HALL, MELISSA	4,800
		DOLB071A20481	James L. Durrence	2,400
		DOLB071A20482	STEENBERGEN, JOHN	14,400
		DOLB071A20483	Linda Gilberto	2,400
		DOLB071A20484	ZsaZsa Ingram Fitzpatrick	2,400
		DOLB071A20486	CARBONE, JOSEPH	2,400
		DOLB071A20487	BISHOP, MOLLY	5,100
		DOLB071A20489	Annette Roane	2,400
		DOLB071A20499	REEVES & ASSOCIATES CONSULTING AND	3,500
		DOLB071A20503	TWYMAN, GLORIA	0
		DOLB071A20504	Louis Wright	0
		DOLB071A20505	WOMANPOWER	15,000
		DOLB071A20508	THOMSON LEARNING, INC	4,458
		DOLB071A20515	HOME ADVANTAGE PLUS LLC	3,825
		DOLB071A20516	REBAR, ANDRA	12,099
		DOLB071A20518	Louis Wright	4,500
		DOLB071A20519	TWYMAN, GLORIA	11,400
		DOLB071A20520	EXHIBIT PROMOTIONS PLUS INC	2,840
		DOLB071A20522	Harvey Ollis	6,000
		DOLB071A20523	DOBBINS, JEAN	9,300
		DOLB071A20525	AMERICAN UNIVERSITY	9,900
		DOLB071A20528	Sarajeon Thompson	7,200
		DOLB071A20529	HODSON, LINDA K	2,400
		DOLB071A20530	Laura Cesario	7,800
		DOLB071A20532	Carl Prince	2,400
		DOLB071A20533	KELLEY-CUSEY, REBECCA	2,400
		DOLB071A20536	Tim Ayoub	5,100
		DOLB071A20537	WILLIAMS, NATHAN	5,100
		DOLB071A20539	Carol Kapolka	2,400
		DOLB071A20541	CORNELL, CLAIRE	2,400
		DOLB071A20546	Richard E. Rizo	5,100
		DOLB071A20547	TROST, MARCY	5,100
		DOLB071A20548	Carolyn Doolittle	2,400
		DOLB071A20552	MARSHALL, M KAREN	4,500
		DOLB071A20554	BAKKER, JANEL	2,100
		DOLB071A20557	Jean Bukovac	2,100
		DOLB071A20562	COX, DAN	4,800
		DOLB071A20565	Kimberly Erwin	2,100
		DOLB071A20566	JOHNSON, ERIC	5,100
		DOLB071A20567	RANDI BLUMENTHAL-GUIGUI	2,100
		DOLB071A20568	JANUSIK, LAURA A	2,100
		DOLB071A20570	AMERICAN SOCIETY FOR TRAINING & DEV	32,500
		DOLB071A20571	BAYLOR, CONCHITA	4,800
		DOLB071A20572	Nicole Lawrence	2,100
		DOLB071A20573	Alyssa Morgan	2,100
		DOLB071A20574	Pat Nolan	2,100
		DOLB071A20575	Brian Deaton	2,400
		DOLB071A20578	MALOUF INC	19,389
		DOLB071A20580	EDUCATION & WORKFORCE CONSULTANTS	1,200
		DOLB071A20582	PROSPERITY ENTERPRISE, INC	1,500
		DOLB071A20583	Thomas M Turner	1,200
		DOLB071A20584	Tuuli Pesonen	2,700
		DOLB071A20586	Tyrone Allen	2,700
		DOLB071A20588	Jill Conlon	2,700
		DOLB071A20589	Dori Rutherford	2,700
		DOLB071A20590	Christine Cremer	2,700

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FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB071A20591	TKC INTEGRATION SERVICES LLC	63,133
			DOLB071A20593	JAMES M. MCCONNELL	4,800
			DOLB071A20594	CARROLL, PATRICIA A	4,800
			DOLB071A20595	Solanga Alves	2,700
			DOLB071A20597	WASHINGTON COURT HOTEL	11,242
			DOLB071A20598	MANAGEMENT CONSULTING ASSOC	20,000
			DOLB071A20604	CHOMA ZENOWIA	2,700
			DOLB071A20605	Delores Battle	2,700
			DOLB07EA20861	PITNEY BOWES	13,777
			DOLB07FA21118	DATAMAX OFFICE SYSTEMS	1,056
			DOLB07FA21294	SHARP ELECTRONICS CORPORATION	2,822
			DOLB07FA21350	AJLA MEETING ACCOUNT	150
			DOLB07FA21433	NATIONAL ASSOCIATION OF STATE	450
			DOLB07FA21444	NATIONAL ASSOCIATION OF STATE	420
			DOLB07FA21554	NEW HAMPSHIRE EMPLOYMENT SECURITY	350
			DOLB07GA20216	PANASONIC DOCUMENT IMAGING COMPANY	1,401
			DOLB07GA20217	PANASONIC DOCUMENT IMAGING COMPANY	2,229
			DOLB07GA20218	PANASONIC DOCUMENT IMAGING COMPANY	1,401
			DOLB07GA20219	PANASONIC DOCUMENT IMAGING COMPANY	1,401
			DOLB07GN20261	WROC INC	10,735
			DOLJ051A20105	AGUIRRE INTERNATIONAL	1,026,138
			DOLJ061A20329	EXCEED CORPORATION	1,700,219
			DOLJ061A20379	The Charter Oak Group	1,537,440
			DOLJ061A20407	M. H. WEST & CO., INC.	1,569,041
			DOLJ071A20438	BERKELEY POLICY ASSOCIATES	3,383,479
			DOLJ071A20510	REDDY PAVAN V	120,000
			DOLJ071A20521	EXCEED CORPORATION	1,186,102
			DOLJ071A20526	CALVIN COLLEGE	97,460
			DOLJ071A20599	CMW & ASSOCIATES INC	323,194
			DOLJ071A20601	M. H. WEST & CO., INC.	250,000
			DOLJ071A20603	HEITECH SERVICES INC	500,000
		NOT COMPETED UNDER SIMP ACQ PROC	DOLB051A20226	SIMON, MELISSA	5,100
			DOLB061A20395	KOSHUTA, MONICA A	7,200
			DOLB061A20398	LYNCH, MEGAN S	2,100
			DOLB061A20399	MELODIA, ANNAMARIE	2,400
			DOLB061A20400	MURPHY, LISA B	3,000
			DOLB061A20402	PIRTLE, JENNIFER	5,700
			DOLB071A20451	MURPHY, LISA B	4,500
			DOLB071A20452	ELEANOR PADGETT	7,500
			DOLB071A20587	Sharon Duckett	2,700
			DOLB07AA20362	NORTHERN BUSINESS MACHINES	2,316
			DOLB07AA20363	PITNEY BOWES INC.	400
			DOLB07AA20364	PITNEY BOWES INC.	400
			DOLB07AA20373	OFFICE FURNITURE DIST OF NEW ENGLAN	12,200
			DOLB07FA21320	NATIONAL ASSOCIATION OF STATE	150
			DOLB07FA21375	FIRESIDE OFFICE PRODUCTS INC	540
			DOLB07FA21381	DORMAN COMMUNICATIONS INC	1,500
			DOLB07FA21407	SHERATON CITY CENTRE HOTEL	1,750
			DOLB07FA21438	ROCKY MOUNTAIN REGIONAL CASU	472
			DOLB07FA21552	NATIONAL ASSOCIATION OF STATE	475
			DOLB07FA21597	NATIONAL ASSOCIATION OF STATE	475
	ILAB	FOLLOW ON TO COMPETED	DOLU079K25784	MACRO INTERNATIONAL, INC	1,167,000
			DOLU079K25788	WILLIAMS ADLEY AND COMPANY L L P	420,000
			DOLU079K25845	MACRO INTERNATIONAL, INC	1,192,886
			DOLU079K26106	MACRO INTERNATIONAL, INC	365,000
		NON-COMPETITIVE DELIVERY ORDER	DOLF079K24490	XEROX CORPORATION	5,542
			DOLF079K24518	XEROX CORPORATION	15,000
		NOT AVAILABLE FOR COMPETITION	DOLB079K25123	FEMCO, INC	6,031

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
		NOT COMPETED	DOLB079K24648	T-MOBILE USA, INC.	33,000
			DOLB079K24711	SMITH, SHIRLEY	5,010
			DOLB079K25852	GEORGETOWN UNIVERSITY	24,440
			DOLB07F821001	APPLE COURIER INCORPORATED	8,000
	JobCorps	FOLLOW ON TO COMPETED	DOLB079A25525	TCCOMBS AND ASSOCIATES LIMITED LIAB	348,254
			DOLJ041A10013	IUPAT JOB CORPS PROGRAM	7,973,301
			DOLU079625810	PROMOTABLES LLC	99,900
			DOLU079A25701	TATC CONSULTING CORPORATION	209,980
		NON-COMPETITIVE DELIVERY ORDER	DOLB079A25110	DIGITAL MANAGEMENT, INC	134,243
			DOLB079A25179	CREATIVE INFORMATION TECHNOLOGY, IN	747,263
			DOLB079A25183	DIGITAL MANAGEMENT, INC	150,003
			DOLB079A25557	ORACLE USA, INC	755,714
			DOLB07FA21088	T-MOBILE USA, INC.	74,453
			DOLF051A20038	HUNTER RICE PC	539,252
			DOLF071A20494	R. NAVARRO & ASSOCIATES, CPA'S	690,792
			DOLF079624947	SYBASE, INC.	208,616
			DOLF079624950	SYBASE, INC.	35,000
			DOLF079626404	NCS PEARSON INC	22,772
			DOLF079A24914	PITNEY BOWES INC	45,729
			DOLF079A25045	COMSTOR CORPORATION	5,364
			DOLF079A25256	CELLCO PARTNERSHIP DBA VERIZON WIRE	13,200
			DOLF079A25543	SOFTCHOICE CORPORATION	158,816
			DOLF079A26184	OCE NORTH AMERICA, INC	8,772
			DOLF079A26284	DISTRIBUTED SOLUTIONS, INC	162,522
		NOT AVAILABLE FOR COMPETITION	AE128550000330	EXCEED CORPORATION	105,449
			AE134030000310	BBIX L.L.C.	80,159
			AE134090000310	POWELL & PARTNERS, ARCHITECTS	20,000
			AE134250000310	KING, DONALD I ARCHITECTS	183,386
			AE135870000410	ABO CERVANTES LOOS PRIEBE ARCHITECT	43,477
			AE94017000	JACKSON PIERCE PUBLIC AFFAIRS INCOR	302,003
			AE98046000	SOUTH DAKOTA, STATE OF	125,638
			DOLAE63405500	CHEROKEE NATION THE	5,101,036
			DOLB071A20498	DAKOTA 2000, INC	188,737
			DOLB071A20506	DAKOTA 2000, INC	65,200
			DOLB071A20513	DAKOTA 2000, INC	86,583
			DOLB071A20524	DAKOTA 2000, INC	1,125,086
			DOLB079625197	FIRST FINANCIAL ASSOCIATES INC	426,400
			DOLB079626244	ABN TECHNOLOGIES LLC	95,000
			DOLB079626253	TIDEWATER INC	38,561
			DOLB079626301	MICROTECH LLC	693,797
			DOLB079A24830	GROUP INTERACTIVE, INC.	17,028
			DOLB079A25270	MANILA CONSULTING GROUP, INC.	615,004
			DOLB079A25272	MANILA CONSULTING GROUP, INC.	690,662
			DOLB079A25404	TCCOMBS & ASSOCIATES, LLC	345,457
			DOLB079A25468	WATERFRONT TECHNOLOGIES, INC	972,061
			DOLB079A25586	EN POINTE GOV INCORPORATED	49,085
			DOLB079A25609	AITHERAS LIMITED LIABILITY COMPANY	189,720
			DOLB079A25630	EMPOWERMENT TECHNOLOGY, INC	214,760
			DOLB079A25686	TKC INTEGRATION SERVICES LLC	69,108
			DOLB079A26056	AITHERAS LIMITED LIABILITY COMPANY	268,176
			DOLJ041A00005	MAK ARCHITECTS, INC.	38,985
			DOLJ04RA00001	ALUTIIQ PROFESSIONAL SERVICES LLC	9,444,505
			DOLJ051A20101	MCNEIL WEST CONSTRUCTION, INC.	4,964
			DOLJ05PA00002	AFFORDABLE SUPPLY COMPANY	138,335
			DOLJ05SA00004	INNOVATIONS GROUP INCORPORATED	1,298,445
			DOLJ06YA30200	CONFEDERATED SALISH AND KOOTENAI TR	3,424,434
			DOLJ079624828	BSI CONTRACTING, INC.	2,405,400
			DOLJ079625387	MECX, L.L.C.	969,950
			DOLJ079625514	MACRO-Z TECHNOLOGY COMPANY	189,312
			DOLJ079625579	BURTON CONSTRUCTION, INC	601,129

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		J04YA22077	MINACT INCORPORATED	4,582,734
		JC010200307BAE90007000	CHUGACH MCKINLEY INC	10,238,721
	NOT COMPETED	AE1258550000330	EXCEED CORPORATION	150,000
		AE134220000345	HONEYWELL INTERNATIONAL	260,957
		AE137460000410	POTTER & ASSOCIATES ARCHITECTS, PLL	19,773
		DOL041A10004	UAW LABOR EMPLOYMENT & TRAINING COR	889,222
		DOLB06UA00358	WILSON, SPENCER	4,525
		DOLB06UA00371	MINACT INC	7,710
		DOLB06UA00372	WILSON, SPENCER	975
		DOLB071A20493	HONEYWELL INTERNATIONAL INC	22,163
		DOLB071A20497	DAKOTA 2000, INC	465,044
		DOLB079626034	NCS PEARSON, INC	14,619
		DOLB079626191	UNITED STATES POSTAL SERVICE	3,800
		DOLB079626529	COMMUNICATIONS PROFESSIONALS INC.	5,603
		DOLB079626582	CCH INCORPORATED	3,940
		DOLB079626584	B I G ENTERPRISES, INC	83,200
		DOLB079A24595	PROQUEST INFORMATION AND LEARNING C	7,870
		DOLB079A24865	ECONOMY COM INC	5,918
		DOLB079A24958	INFORMATION FOR PUBLIC AFFAIRS, INC	21,392
		DOLB079A25180	CONGRESSIONAL QUARTERLY, INC	2,854
		DOLB079A25289	ENTERPRISE SOLUTIONS, INC	13,500
		DOLB079A25295	SCM SOLUTIONS INC	8,990
		DOLB079A25472	COMMUNICATIONS PROFESSIONALS	18,509
		DOLB079A25480	HANDYSOFT CORPORATION	23,199
		DOLB079A25605	DIGITAL MANAGEMENT INC	159,963
		DOLB079A25714	SPI UNK TECHNOLOGY	8,500
		DOLB079A26250	CREATIVE INFORMATION TECHNOLOGY INC	834,765
		DOLB07KA20103	SPRINT SPECTRUM L P	45,110
		DOLJ041A00030	McConnell, Jones, Lanier, & Murphy	810,000
		DOLJ041A10003	IUOE JOB CORPS TRAINING PROGRAM	2,409,076
		DOLJ041A10004	UAW LABOR EMPLOYMENT & TRAINING COR	1,516,192
		DOLJ041A10006	National Plastering Industry's JATF	8,990,538
		DOLJ041A10008	Transportation Communication Interna	1,382,377
		DOLJ041A10009	HOME BUILDERS INSTITUTE	4,005,339
		DOLJ041A10010	UBC National Job Corps and Training	13,991,641
		DOLJ041A10012	INTERNATIONAL MASONRY INSTITUTE	3,949,314
		DOLJ04PA00001	JACKSON PIERCE PUBLIC AFFAIRS INCOR	404,370
		DOLJ04PA00005	JACKSON PIERCE PUBLIC AFFAIRS INCOR	366,951
		DOLJ051A20002	Lombard Conrad Architects, P.A.	1,424
		DOLJ051A20154	MATANUSKA-SUSITNA BOROUGH	1
		DOLJ051A20156	RELIANCE TRUST COMPANY	205,560
		DOLJ051A20160	Wulsin, L.L.C.	196,370
		DOLJ051A20161	DEPARTMENT OF EDUCATION OF PUERTO R	1
		DOLJ051A20162	GLYNN COUNTY BOARD OF COMMISSIONERS	194,315
		DOLJ051A20163	GENERAL ADMINISTRATION, WASHINGTON	530,000
		DOLJ051A20164	JORGENSEN, RICHARD B.	7,858
		DOLJ051A20165	Marc R. Jensen	31,062
		DOLJ051A20167	NORTHEAST OHIO REGIONAL SEWER DISTR	25,000
		DOLJ051A20168	Paul Ort, MD	3,000
		DOLJ051A20169	CATHOLIC DIOCESE OF KANSAS CITY-ST.	36,714
		DOLJ051A20170	GADSDEN STATE COMMUNITY COLLEGE	1
		DOLJ051A20171	GADSDEN STATE COMMUNITY COLLEGE	1
		DOLJ051A20172	COMMONWEALTH OF MASSACHUSETTS	1
		DOLJ051A20173	GULFPORT, CITY OF	1
		DOLJ051A20174	LAND AND NATURAL RESOURCES, HAWAII	7,400
		DOLJ051A20175	LUZERNE COUNTY OF	43,062
		DOLJ051A20176	PAN PACIFIC VENTURES	528,000
		DOLJ051A20177	Y W C A OF GREATER LOS ANGELES INC	286,500
		DOLJ051A20178	Fisch Properties LP	51,000
		DOLJ051A20179	NORMAN, DAVID	158,975
		DOLJ051A20180	City of Crystal Springs, Mississippi	47,850
		DOLJ051A20181	VERMONT, STATE OF	261,660
		DOLJ051A20182	MISSIONARY SERVANTS OF THE MOST HOL	391,079

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLJ051A20183	General Services, New York Office	334,000
		DOLJ051A20184	URBAN EDUCATION DEVELOPMENT RESEARC	549,495
		DOLJ051A20187	UNITED STATES DEPARTMENT OF THE NAV	557,104
		DOLJ051A20188	PORTFOLIO REALTY MANAGEMENT INC	137,099
		DOLJ051A20190	DEKALB AVENUE ASSOCIATES LLC	935,518
		DOLJ051A20191	Montgomery Park Company, LLC	182,223
		DOLJ051A20192	Lincoln Foundation, Inc.	374,822
		DOLJ051A20193	GENERAL SERVICES, MARYLAND DEPARTME	1
		DOLJ051A20213	Pangea, Inc.	33,354
		DOLJ061A20339	CONFEDERATED SALISH AND KOOTENAI TR	1
		DOLJ061A20414	TIDEWATER INC	467,703
		DOLJ069124368	KOFI CONSULTING SERVICES INCORPORAT	88,317
		DOLJ069624385	PBDEWBERRY	21,395,766
		DOLJ069624415	MC KISSACK & MC KISSACK OF WASHINGT	4,747,466
		DOLJ06YA35022	CHUGACH INDUSTRIES INCORPORATED	6,547,830
		DOLJ071A20492	THE UNIVERSITY OF IOWA	1,000,000
		DOLJ079624961	THE MC GRAW-HILL COMPANIES INC	410,000
		DOLJ079625278	ABN TECHNOLOGIES LLC	1,512,828
		DOLJ079625486	HEITECH SERVICES INC	450,000
		DOLJ079625632	TRIBALCO, LLC	1,527,931
		DOLJ079625786	FACILITIES DEVELOPMENT CORP	1,089,156
		DOLJ079A25330	MCNEIL TECHNOLOGIES, INC.	511,432
	NOT COMPETED UNDER SIMP ACQ PROC			
		DOLB079625719	BATTELLE MEMORIAL INSTITUTE	100,000
		DOLB079625735	MOTION PICTURE LICENSING CORP	13,749
		DOLB079626419	TENABLE NETWORK SECURITY, INC.	3,600
		DOLB07QA20002	ECLIPSE VIDEO SERVICES INC	1,521
		DOLB07QA20003	ECLIPSE VIDEO SERVICES INC	1,024
		DOLB07QA20004	ECLIPSE VIDEO SERVICES INC	969
	MSHA			
	FOLLOW ON TO COMPETED			
		DOLB064R20716	NEXTEL COMMUNICATIONS OF THE MID-AT	328
		DOLB06MR20328	ACME AUTO LEASING LLC	8,220
		DOLB074R21055	F M F CORP	49,873
		DOLB074R21056	FEDSOURCE BALTIMORE	361,955
		DOLB07MR20365	IKON OFFICE SOLUTIONS, INC.	6,683
		DOLB07MR20381	FEDSOURCE DENVER	9,180
	NON-COMPETITIVE DELIVERY ORDER			
		DOLF064R20990	NELSON, CHARLES R.	0
		DOLF074R21358	TECHNICAL MANAGEMENT SERVICES	160,000
		DOLF074R21370	NELSON, CHARLES R.	50,000
		DOLF074R21569	SKC, INC.	37,954
		DOLF07MR20335	MIDTOWN PERSONNEL INC	43,500
		DOLF07MR20360	IRON MOUNTAIN INCORPORATED	15,214
		DOLF07MR20423	DATAWIZ CORPORATION	7,299
		DOLF07MR20439	SKC, INC.	25,335
		DOLF07MR20503	KYOCERA MITA AMERICA INC	1,200
	NOT AVAILABLE FOR COMPETITION			
		DOLB064R20526	VERIZON NEW ENGLAND INC	100
		DOLB064R20549	VERIZON CALIFORNIA INC.	500
		DOLB074R21006	A T & T CORP	0
		DOLB074R21010	COMCAST CABLE COMMUNICATIONS, INC.	663
		DOLB074R21012	YOUR ANSWERING SERVICE, INC	389
		DOLB074R21014	THACKER-GRIGSBY TELEPHONE COMPANY I	1,800
		DOLB074R21015	PUERTO RICO TELEPHONE COMPANY INC.	720
		DOLB074R21018	OHIO BELL TELEPHONE COMPANY, THE (I	2,400
		DOLB074R21019	CITIZENS TELECOMMUNICATIONS COMPANY	3,480
		DOLB074R21020	CITIZENS TELECOMMUNICATIONS COMPANY	5,240
		DOLB074R21021	CARBONEMERY TELCOM, INC.	2,760
		DOLB074R21022	FIBERNET, LLC	24,000
		DOLB074R21025	VERIZON NORTH INC.	1,920

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB074R21026	WINDSTREAM CORPORATION	7,320
		DOLB074R21027	WINDSTREAM CORPORATION	16,079
		DOLB074R21030	VERIZON WEST VIRGINIA INC.	720
		DOLB074R21031	VERIZON PENNSYLVANIA INC.	13,872
		DOLB074R21032	VERIZON PENNSYLVANIA INC.	2,160
		DOLB074R21033	VERIZON MARYLAND INC	5,700
		DOLB074R21034	VERIZON MARYLAND INC	12,600
		DOLB074R21038	AMERICAN ELECTRIC POWER COMPANY, IN	1,164
		DOLB074R21041	ABCO FIRE PROTECTION INC PA	800
		DOLB074R21042	VERIZON FLORIDA INC.	3,360
		DOLB074R21044	ABCO FIRE PROTECTION INC PA	2,250
		DOLB074R21047	QWEST GOVERNMENT SERVICES, INC.	32,280
		DOLB074R21058	ADELPHIA COMMUNICATIONS	925
		DOLB074R21061	AMERICAN ELECTRIC POWER COMPANY, IN	3,360
		DOLB074R21064	CENTERPOINT ENERGY GAS TRANSMISSION	4,200
		DOLB074R21082	KENTUCKY UTILITIES COMPANY	900
		DOLB074R21087	RALEIGH COUNTY PUBLIC SERVICE DISTR	85,000
		DOLB074R21088	BECKLEY, CITY OF	53,000
		DOLB074R21090	MOUNTAINEER GAS COMPANY	55,000
		DOLB074R21091	BELLSOUTH BUSINESS SYSTEMS, INC	20,100
		DOLB074R21092	BELL SOUTH BUSINESS SYSTEMS, INC	37,374
		DOLB074R21104	ADELPHIA COMMUNICATIONS	553
		DOLB074R21106	SOUTHWESTERN BELL TELEPHONE, LIMITE	3,480
		DOLB074R21109	WEST PENN POWER COMPANY	252
		DOLB074R21110	TELECOMMUNICATIONS MANAGEMENT, LLC	780
		DOLB074R21115	DIRECTV, INC.	480
		DOLB074R21117	NORTH PITTSBURGH TELEPHONE COMPANY	9,540
		DOLB074R21118	FRONTIER COMMUNICATIONS OF IOWA INC	2,940
		DOLB074R21119	CENTRAL TELEPHONE COMPANY	3,375
		DOLB074R21121	AMERITECH SERVICES INC (DEL)	10,620
		DOLB074R21122	OHIO COUNTY PUBLIC SERVICE DISTRICT	21,381
		DOLB074R21123	NORTH HILLS ANSWERING SERVICE INC	256
		DOLB074R21126	CROSSCOUNTRY FULFILLMENT, LLC	400
		DOLB074R21129	VERIZON MARYLAND INC	39,600
		DOLB074R21133	VERIZON NEW YORK INC	5,960
		DOLB074R21135	FEDERAL TECHNOLOGY SERVICE LONG DIS	131,716
		DOLB074R21139	WYCLIFFE ENTERPRISES, INC	26,086
		DOLB074R21161	BUCKEYE PEST MANAGEMENT INC	1,540
		DOLB074R21177	A T & T COMMUNICATION SERVICES INTE	720
		DOLB074R21190	ACS WIRELESS, INC	899
		DOLB074R21193	SPRINT SPECTRUM L.P.	1,370
		DOLB074R21194	ALLTEL CELLULAR ASSOCIATES OF SC LI	240
		DOLB074R21201	CEQUEL COMMUNICATIONS LIMITED LIAB	20,128
		DOLB074R21203	CEQUEL COMMUNICATIONS LIMITED LIAB	619
		DOLB074R21205	CEQUEL COMMUNICATIONS LIMITED LIAB	708
		DOLB074R21211	CONSOLIDATED COMMUNICATIONS	1,920
		DOLB074R21212	GATEWAY TELECOM LLC	10,620
		DOLB074R21214	M & W CONTRACTORS INC	420
		DOLB074R21215	NTELOS INC	756
		DOLB074R21218	CHARLOTTESVILLE CELLULAR PARTNERSHI	600
		DOLB074R21220	CENTRAL TELEPHONE COMPANY OF VIRGIN	4,200
		DOLB074R21222	AQUIS COMMUNICATIONS	326
		DOLB074R21229	SPRINT COMMUNICATIONS COMPANY L.P.	960
		DOLB074R21232	ALLTEL CORPORATION	816
		DOLB074R21234	ONLINE SATELLITE COMMUNICATIONS	17,858
		DOLB074R21247	WINDSTREAM CORPORATION	1,375
		DOLB074R21255	UNITY ACQUISITIONS, INC	2,112
		DOLB074R21256	TELESPECTRUM COMMUNICATIONS, INC.	160
		DOLB074R21257	ALLTEL CORPORATION	540
		DOLB074R21259	ALLTEL CORPORATION	674
		DOLB074R21276	CITY OF MCALESTER	960
		DOLB074R21278	VALOR TELECOMMUNICATIONS OF TEXAS,	4,080
		DOLB074R21279	EMBARQ MISSOURI, INC	3,600

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB074R21281	TELEMESSAGING SERVICES INC	960
		DOLB074R21282	SIGNIUS COMMUNICATIONS INC	632
		DOLB074R21284	SOUTHWESTERN BELL TELEPHONE, LIMITE	3,000
		DOLB074R21286	CTSI, LLC	7,200
		DOLB074R21290	WYCLIFFE ENTERPRISES, INC	5,465
		DOLB074R21300	PINGTONE COMMUNICATIONS INC	3,879
		DOLB074R21303	VERIZON CALIFORNIA INC.	4,480
		DOLB074R21305	PACIFIC BELL (TELEPHONE COMPANY)	8,074
		DOLB074R21325	MOUNTAINEER PUBLISHING CO INC	158
		DOLB074R21329	EMBARQ MISSOURI, INC	5,249
		DOLB074R21336	MOUNTAINEER PUBLISHING CO INC	184
		DOLB074R21341	OXBOW CORPORATION	350
		DOLB074R21374	VERIZON PENNSYLVANIA INC.	1,959
		DOLB074R21406	WYCLIFFE ENTERPRISES, INC	2,680
		DOLB074R21456	WYCLIFFE ENTERPRISES, INC	16,050
		DOLB074R21457	WYCLIFFE ENTERPRISES, INC	2,591
		DOLB074R21465	ELECTRONIC SPECIALTY COMPANY	27,748
		DOLB074R21466	SEEBACH AMERICA INC	1,911
		DOLB074R21493	PROFESSIONAL SERVICES OF AMERICA, I	938
		DOLB074R21514	WYCLIFFE ENTERPRISES, INC	7,446
		DOLB074R21519	WYCLIFFE ENTERPRISES, INC	3,000
		DOLB074R21540	EAGLE DESIGN, INC	35,019
		DOLB074R21546	SARGENT'S COURT REPORTING SERVICE,	50,000
		DOLB07MR20346	UNICOR, FEDERAL PRISON INDUSTRIES	2,000,000
		DOLB07MR20408	HISPANIC ASSOCIATION OF COLLEGES AN	10,044
		DOLB07MR20431	GLOBAL TECH INC	19,255
		DOLB07MR20474	DATAWIZ CORPORATION	28,450
		DOLB07MR20487	TKC INTEGRATION SERVICES LLC	42,971
		DOLB07MR20491	HEARING SAFETY	3,000
		DOLB07MR20502	DATAWIZ CORPORATION	6,188
		DOLB07MR20512	GTP INCORPORATION	27,638
		DOLJ05MR20017	DATAWIZ CORPORATION	205,100
		DOLJ05MR20070	WHEELING JESUIT UNIVERSITY	675,000
		DOLJ074R21040	MONONGAHELA POWER COMPANY	105,000
		DOLJ074R21066	AMERICAN ELECTRIC POWER COMPANY, IN	102,180
		DOLJ074R21067	AMERICAN ELECTRIC POWER COMPANY, IN	400,000
		DOLJ074R21557	CONCENTRIC METHODS LLC	552,032
		DOLJ074R21571	EAGLE DESIGN, INC	395,581
		DOLJ074R21586	INUKTUN SERVICES LTD	125,955
		DOLJ07MR20428	DATAWIZ CORPORATION	170,000
		DOLJ07MR20447	TIGER PERSONNEL SERVICES, INC.	60,060
		DOLJ07MR20494	FEDERAL PRISON INDUSTRIES INCORPORA	300,000
	NOT COMPETED	DOLB064R20983	CASTLE ROCK SPECIAL HOSPITAL DISTRI	401
		DOLB064R20988	MASCOLINO, THOMAS	25,000
		DOLB074R21007	SIGNIUS COMMUNICATIONS INC	316
		DOLB074R21062	AAA GARAGE	9,800
		DOLB074R21070	KERR, WILLIAM DENNIS & SONS INC	39,314
		DOLB074R21073	PRO KIL PEST CONTROL	550
		DOLB074R21074	PERKINELMER LAS, INC	22,801
		DOLB074R21075	WEST VIRGINIA PARKWAYS AUTHORITY	4,800
		DOLB074R21076	VIDEOJET TECHNOLOGIES INC	14,004
		DOLB074R21080	PANALYTICAL INC	36,584
		DOLB074R21085	MOUNT HOPE, CITY OF	8,400
		DOLB074R21112	MARSHALL UNIVERSITY	32,580
		DOLB074R21124	METTLER-TOLEDO, INC.	5,859
		DOLB074R21128	SYL WORHACZ FORD, INC.	2,626
		DOLB074R21131	GLOBAL DOSIMETRY SOLUTIONS INC	1,162
		DOLB074R21134	DULUTH, CITY OF	2,520
		DOLB074R21138	INDUSTRIAL ELECTRIC CORP	1,900
		DOLB074R21140	INDUSTRIAL ELECTRIC CORP	24,400
		DOLB074R21166	FAIRMONT GENERAL HOSPITAL INC	510
		DOLB074R21206	CALIPER LIFE SCIENCES, INC	17,640
		DOLB074R21221	DEMUTH, CONNIE	330

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB074R21226	REMOTEC, INC.	9,200
		DOLB074R21227	LEES, RICHARD	3,600
		DOLB074R21235	AMERICAN INDUSTRIAL HYGIENE ASSOCIA	6,140
		DOLB074R21270	SERVICE ELECTRIC TELEVISION INC	780
		DOLB074R21271	MISSCO INC	1,273
		DOLB074R21273	ASSOCIATES SPEECH & HEARING	1,540
		DOLB074R21285	MOBILE SATELLITE VENTURES LP	14,647
		DOLB074R21302	OPTIMUM PRODUCTIONS SERVICES INC	7,270
		DOLB074R21312	MILLER COURT REPORTERS	8,250
		DOLB074R21313	BECKLEY HEARING CENTER INC	2,125
		DOLB074R21316	MONONGALIA COUNTY HEALTH DEPT.	660
		DOLB074R21318	HEARING PLACE, THE	625
		DOLB074R21319	QUALITY SYSTEMS INTERNATIONAL CORPO	7,000
		DOLB074R21328	WYCLIFFE ENTERPRISES, INC	6,812
		DOLB074R21332	NEOPOST INC	14,773
		DOLB074R21343	MARK E. PATTON, LTD	9,975
		DOLB074R21348	NDT TECHNOLOGIES INC	2,442
		DOLB074R21349	JAMES E DAMRON	800
		DOLB074R21366	KRM COURT REPORTING	172
		DOLB074R21367	WEST KENTUCKY REPORTING SERVICE	2,185
		DOLB074R21393	QUALITY SYSTEMS INTERNATIONAL CORPO	4,500
		DOLB074R21400	CEQUEL III COMMUNICATIONS I, LLC	1,188
		DOLB074R21405	SUPERFLOW CORPORATION	20,778
		DOLB074R21413	AMERICAN MESSAGING SERVICES, LLC	125
		DOLB074R21415	MUCHO THOMAS P & ASSOC INC	32,463
		DOLB074R21435	OPRYLAND HOSTIPALITY	45,000
		DOLB074R21439	OPRYLAND HOSTIPALITY	4,500
		DOLB074R21443	RENO SPARKS CONVENTION VISITORS AUT	27,360
		DOLB074R21444	HOT DESIGNS	278
		DOLB074R21450	HOT DESIGNS	839
		DOLB074R21452	HOLMES SAFETY ASSOCIATION	6,500
		DOLB074R21454	BASIC CONTRACTING SERVICES, INC	5,558
		DOLB074R21455	MASCOLINO, THOMAS	95,000
		DOLB074R21458	NEVIN DAVIS	2,000
		DOLB074R21462	OPRYLAND HOSTIPALITY	19,915
		DOLB074R21474	DISTINCTIVE PROMOTIONS INC	3,838
		DOLB074R21480	OPRYLAND HOSTIPALITY	15,005
		DOLB074R21483	GERALD DRANSITE CONSULTING	26,308
		DOLB074R21492	RIVERSIDE INDUSTRIAL MEDICAL CLINIC	900
		DOLB074R21497	DAVIS INOTEK INSTRUMENTS, LLC	52,530
		DOLB074R21501	WYCLIFFE ENTERPRISES, INC	7,321
		DOLB074R21504	WEST VIRGINIA DIV OF LABOR	100
		DOLB074R21517	CASTLE ENVIRONMENTAL INC	2,090
		DOLB074R21518	PANALYTICAL INC	31,011
		DOLB074R21520	CALIPER LIFE SCIENCES, INC	13,750
		DOLB074R21524	JESSE P. COLE	400
		DOLB074R21525	WYCLIFFE ENTERPRISES, INC	7,284
		DOLB074R21534	THERMO ENVIRONMENTAL INSTRUMENTS IN	25,853
		DOLB074R21535	MINE SAFETY APPLIANCES COMPANY	94,470
		DOLB074R21543	WEST KENTUCKY REPORTING SERVICE	10,000
		DOLB074R21544	BRUEL & KJAER NORTH AMERICA INC	49,797
		DOLB074R21545	HISPANIC ASSOCIATION OF COLLEGES &	12,500
		DOLB074R21586	C S E CORPORATION	34,822
		DOLB074R21584	EASTERN OKLAHOMA STATE COLLEGE INCO	90
		DOLB074R21633	SARGENT'S COURT REPORTING SERVICE,	6,500
		DOLB07MR20330	inter parking corp	13,680
		DOLB07MR20397	INTERPARK HOLDINGS, INC	15,930
		DOLB07MR20434	WHEELING JESUIT UNIVERSITY	20,000
		DOLB07MR20456	HISPANIC ASSOCIATION OF COLLEGES AN	11,314
		DOLB07MR20462	INTEGRIS INCORPORATED	93,342
		DOLB07MR20469	HAROLD L OWENS PE, PLLC	14,000
		DOLB07MR20470	Ronald Schell	100,000
		DOLB07MR20525	ROCSCIENCE INC	59,165

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLJ064R20586	SUPERIOR JANITORIAL SERVICES, INC	85,393
		DOLJ074R21242	DAVIS INOTEK INSTRUMENTS, LLC	106,935
		DOLJ074R21404	CSE CORPORATION	107,681
		DOLJ074R21653	A-TECH SYSTEMS INC	300,000
		DOLJ07MR20484	OPRYLAND HOSPITALITY LLC	125,000
	NOT COMPETED UNDER SIMP ACQ PROC	DOLB06MR20203	BUCKEYE COPIER SALES	228
		DOLB06MR20213	TREASURY FRANCHISE FUND, US	1,396
		DOLB074R21048	MAKO ELECTRIC CO INC	2,490
		DOLB074R21052	BECKLEY RALIEGH COUNTY BOARD OF HEA	1,150
		DOLB074R21059	STERICYCLE, INC	250
		DOLB074R21068	HENDERSON TRANSFER CO	720
		DOLB074R21071	THRANE & THRANE INC.	1,260
		DOLB074R21072	LINWELD, INC.	1,784
		DOLB074R21078	ROGER ANGELELLI	2,475
		DOLB074R21079	R J L INC	1,143
		DOLB074R21081	GREENBRIER FIRE PROTECTION	800
		DOLB074R21083	ELBERTON GRANITE ASSOCIATION, INC.	1,250
		DOLB074R21085	AQUA FILTER FRESH INC	876
		DOLB074R21096	IRON CITY INDUSTRIAL CLEANING CORPO	1,400
		DOLB074R21098	CINTAS CORPORATION	1,721
		DOLB074R21099	A A A ALARM SYSTEMS	90
		DOLB074R21100	GUEST, INC	720
		DOLB074R21101	WHITMAN EXTERMINATING COMPANY	1,580
		DOLB074R21105	ARTESIAN LABORATORIES INC	325
		DOLB074R21107	ELBERTON GRANITE ASSOCIATION, INC.	1,500
		DOLB074R21114	FAMILY HEARING SERVICES INC	605
		DOLB074R21116	U-HAUL INTERNATIONAL INC	173
		DOLB074R21151	CROSHERS SANITARY SERVICE INC	1,980
		DOLB074R21167	PITNEY BOWES INC	1,322
		DOLB074R21171	ALLEGHENY SURVEYS, INC.	3,800
		DOLB074R21173	AIRGAS MID AMERICA, INC	365
		DOLB074R21175	AIRGAS MID AMERICA, INC.	544
		DOLB074R21176	MATHESON TRI-GAS INC	725
		DOLB074R21178	BECKLEY WELDING SUPPLY INC	1,500
		DOLB074R21180	DELILLE OXYGEN COMPANY	229
		DOLB074R21183	ELBERTON GRANITE ASSOCIATION, INC.	3,185
		DOLB074R21189	SWEET SPRINGS VALLEY WATER COMPANY	2,188
		DOLB074R21197	MABSCOTT SUPPLY COMPANY	1,104
		DOLB074R21199	ALLEGHENY WELDING & INDUSTRIAL SUPP	758
		DOLB074R21200	SCOTT SPECIALTY GASES INC	219
		DOLB074R21202	SCOTT SPECIALTY GASES INC	110
		DOLB074R21204	MABSCOTT SUPPLY COMPANY	589
		DOLB074R21209	PEGGY DIBACCO COURT REPOR	501
		DOLB074R21267	AMERICAN ELECTRIC POWER COMPANY, IN	120
		DOLB074R21268	R L SAGATH MACHINING & FABRICATING	650
		DOLB074R21304	CITY OF MURFREESBORO	68
		DOLB074R21307	NEW WAVE COMMUNICATION	1,070
		DOLB074R21309	ACKENHEIL ENGINEERS INC	450
		DOLB074R21310	HARDIN APPLIANCE INC	152
		DOLB074R21311	BLACKS JANITORIAL AND SWEEPING SERV	7,500
		DOLB074R21333	WEST VIRGINIA UNIVERSITY	125
		DOLB074R21334	BUCKEYE COPIER SALES	80
		DOLB074R21342	PC RENEWAL	75
		DOLB074R21344	WYCLIFFE ENTERPRISES, INC	28,000
		DOLB074R21345	GRIFFIN INDUSTRIES INC	150
		DOLB074R21346	WEST VIRGINIA UNIVERSITY	125
		DOLB074R21347	COLLEGE OF EASTERN UTAH	1,000
		DOLB074R21352	MOUNTAIN BROADCASTING SERVICE, INC.	740
		DOLB074R21353	PEGGY SUE BROADCASTING	1,248
		DOLB074R21355	EASTERN BROADCASTING CO.	672
		DOLB074R21356	HIGH KNOB BROADCASTERS	364

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FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB074R21357	EAST KENTUCKY BROADCASTING	1,692
		DOLB074R21361	UNIVERSITY OF KENTUCKY	6,766
		DOLB074R21362	MST INCORPORATED	613
		DOLB074R21363	UNIVERSITY OF KENTUCKY	3,265
		DOLB074R21368	NE PENNSYLVANIA CENTER FOR IND	530
		DOLB074R21372	GREENBRIER FIRE PROTECTION	1,500
		DOLB074R21376	JOLIETT VOLUNTEER FIRE CO	800
		DOLB074R21381	AVERITT EXPRESS, INC.	250
		DOLB074R21382	ENVIRONMENTAL SERVICES, NEW HAMPSHI	245
		DOLB074R21384	MATTKIM INC	200
		DOLB074R21386	HARLAN DAILY ENTERPRISE	723
		DOLB074R21389	Southeastern Oklahoma Radio, LLC	2,250
		DOLB074R21390	Coleman Broadcasting Service	300
		DOLB074R21391	BIG CHIEF BROADCASTING COMPANY, INC	1,240
		DOLB074R21392	UNIVERSITY OF NEBRASKA	17
		DOLB074R21394	HOT DESIGNS	2,425
		DOLB074R21395	ALPHA ENGINEERING SERVICES INC	400
		DOLB074R21396	REGIONAL EDUCATION SERVICE AGENCY 8	1,980
		DOLB074R21399	MST INC	1,200
		DOLB074R21408	HYATT CORPORATION DEL	11,620
		DOLB074R21412	BLOCKHOUSE DQ INC	28,839
		DOLB074R21414	HORIBA INSTRUMENTS INCORPORATED	10,490
		DOLB074R21416	CHEMBIO SHELTER INC	2,066
		DOLB074R21419	AGAPITO ASSOCIATES, INC	2,450
		DOLB074R21432	W2005 CPT REALTY LLC	360
		DOLB074R21436	COUNTY OF RALEIGH	150
		DOLB074R21437	HAWKINS ELECTRICAL CONTRACTORS, INC	459
		DOLB074R21440	PIKE COUNTY SCHOOL DISTRICT	1,939
		DOLB074R21446	N D T TECHNOLOGIES INCORPORATED	195
		DOLB074R21453	GARRETT REPORTING SERVICE	1,504
		DOLB074R21459	REGIONAL EDUCATION SERVICE AGENCY	85
		DOLB074R21461	WYCLIFFE ENTERPRISES, INC	28,073
		DOLB074R21471	GOODE'S VENTILATION & MINING SUPPLY	400
		DOLB074R21479	WEST VIRGINIA UNIVERSITY	740
		DOLB074R21481	D B T AMERICA INC	2,965
		DOLB074R21484	CALLAHAN, BRUCE	2,393
		DOLB074R21489	HAWKINS ELECTRICAL CONTRACTORS, INC	1,186
		DOLB074R21490	DEMAND ELECTRIC, INC	187
		DOLB074R21505	OPRYLAND HOSTIPALITY	1,380
		DOLB074R21522	SMITH'S SAWDUST STUDIO LTD.	2,899
		DOLB074R21523	ILLINOIS MINING INSTITUTE	1,200
		DOLB074R21526	SEEBACH AMERICA INC	2,592
		DOLB074R21529	WYCLIFFE ENTERPRISES, INC	12,150
		DOLB074R21530	SOJOURN MOVERS	630
		DOLB074R21531	UNIVERSITY OF TEXAS AT AUSTIN	300
		DOLB074R21533	NE PENNSYLVANIA CENTER FOR IND	265
		DOLB074R21537	BUSTER'S STUMP & TREE REMOVAL	350
		DOLB074R21538	UNIVERSITY OF KENTUCKY	7,240
		DOLB074R21541	HOT DESIGNS	2,280
		DOLB074R21549	AVERITT EXPRESS, INC.	600
		DOLB074R21550	UNICOR, FEDERAL PRISON INDUSTRIES,	34,908
		DOLB074R21556	HOT DESIGNS	1,444
		DOLB074R21559	SOFTWARENESS	2,634
		DOLB074R21561	ASPEN OF DC INC	5,070
		DOLB074R21562	NEW RIVER, INC.	968
		DOLB074R21565	SOLARFLO CORPORATION	2,757
		DOLB074R21644	M & W CONTRACTORS INC	125
		DOLB074R21655	NE PENNSYLVANIA CENTER FOR IND	1,452
		DOLB07MR20352	SCOTT, KENNETH M	1,400
		DOLB07MR20357	SETON NAME PLATE	2,379
		DOLB07MR20358	COMCAST CORPORATION (2294)	6,509
		DOLB07MR20372	ILLINOIS VALLEY BUSINESS EQUIPMENT	1,594
		DOLB07MR20387	UNICOR FEDERAL PRISON INDUSTRIES IN	900

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FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB07MR20391	VERIZON FEDERAL INC	1,200
			DOLB07MR20392	FEDERAL LOCK AND SAFE, INCORPORATED	2,500
			DOLB07MR20393	TNT INCORPORATED	894
			DOLB07MR20395	CDW GOVERNMENT INC	1,660
			DOLB07MR20398	TRI-CITY BUSINESS MACHINES CO	1,410
			DOLB07MR20409	MAKO ELECTRIC CO INC	600
			DOLB07MR20424	NEW CINGULAR WIRELESS NATIONAL ACCO	406
			DOLB07MR20451	TRI-CITY BUSINESS MACHINES CO	1,500
			DOLB07MR20471	WASHINGTON METROPOLITAN AREA TRANSI	2,450
			DOLB07MR20505	DANKA HOLDING COMPANY PARENT COMPAN	1,560
			DOLB07MR20506	COMCAST CORPORATION (2294)	6,009
			DOLB74R21442	MAKO ELECTRIC COMPANY INCORPORATED	2,560
			DOLF074R21445	CORT BUSINESS SERVICES CORPORATION	268
	ODEP	FOLLOW ON TO COMPETED	DOLB079426577	SODEXHO, INC	16,687
			DOLU079425225	DEVELOPMENT INFOSTRUCTURE	32,873
			DOLU079425439	DELL MARKETING LIMITED PARTNERSHIP	145,034
			DOLU079425446	TATC CONSULTING CORPORATION	88,813
			DOLU079425796	DEVELOPMENT INFOSTRUCTURE	38,376
			DOLU079425843	CONCEPTS INC	46,195
			DOLU079426031	CONCEPTS INC	475,000
			DOLU079426091	CHERRY ENGINEERING SUPPORT SER	1,657,236
			DOLU079426154	HEALTHCARE DYNAMICS, INC	168,888
			DOLU079426156	CHERRY ENGINEERING SUPPORT SER	61,846
			DOLU079426251	CAPITOL SERVICES INC.	25,528
			DOLU079426336	CONCEPTS INC	54,627
			DOLU079426435	DEVELOPMENT INFOSTRUCTURE	99,019
		NOT AVAILABLE FOR COMPETITION NOT COMPETED	DOLJ069423110	HEITECH SERVICES, INC.	201,041
			DOLB079425380	SOCIETY FOR HUMAN RESOURCE MANAGEME	3,500
			DOLB079426169	THE REGENTS OF THE UNIVERSITY OF CA	5,000
			DOLB079426362	WEST VIRGINIA UNIVERSITY (5758)	1,401,014
			DOLJ079425581	DISABLED SPORTS USA	90,080
	OIG	FOLLOW ON TO COMPETED	DOLJ079426341	WEST VIRGINIA UNIVERSITY (5758)	2,164,099
			DOLB06XG20323	LIGHT, JUDITH CMC	33,400
			DOLB07XG20486	ACL Services LTD	19,148
			DOLU06XG20333	PRICEWATERHOUSECOOPERS LLP	60,832
			DOLU07XG20444	SPRINT COMMUNICATIONS COMPANY	52,726
			DOLU07XG20485	PRICEWATERHOUSECOOPERS LLP	460,112
			DOLU07XG20520	PRICEWATERHOUSECOOPERS LLP	744,346
		NON-COMPETITIVE DELIVERY ORDER	DOLB079425347	POWERTEK CORPORATION	594,489
			DOLF06XG20285	CANON U.S.A., INC	547
			DOLF079424780	CELLCO PARTNERSHIP DBA VERIZON WIRE	13,800
			DOLF07E620738	J B CUBED, INC	10,000
		NOT AVAILABLE FOR COMPETITION	DOLB06XG20312	GLOBAL TECH INC	35,120
			DOLB07XG20527	FEMCO, INC	37,330
		NOT COMPETED	DOLB06XG20351	K&S Government Consulting	2,239
			DOLB06XG20354	Management Solutions, Inc.	3,000
			DOLB07G420194	PANASONIC DOCUMENT IMAGING COMPANY	1,401
			DOLB07G420195	PANASONIC DOCUMENT IMAGING COMPANY	2,229
			DOLB07G420196	PANASONIC DOCUMENT IMAGING COMPANY	1,401
			DOLB07XG20411	L A PARKING CORP	2,208
			DOLB07XG20442	NNA INC	2,772
			DOLB07XG20450	DOCUMENT MANAGERS	5,098
			DOLB07XG20456	CRESTLINE HOTELS & RESORTS INC.	16,024
			DOLB07XG20470	CI TECHNOLOGIES, INCORPORATED	1,260
			DOLB07XG20478	HECKLER & KOCH DEFENSE, INC	3,710
			DOLB07XG20488	F5 NETWORKS INC	3,298
			DOLB07XG20493	JUNIOR ACHIEVEMENT OF CENTRAL INDIA	858
			DOLB07XG20501	HECKLER & KOCH DEFENSE, INC	6,917

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FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB07XG20505	PWC PRODUCT SALES LLC	43,200
			DOLB07XG20506	CASCADES TECHNOLOGIES INC	247,485
			DOLB07XG20507	KROLL ONTRACK, INC	8,855
			DOLB07XG20524	ESTRADA, JOAN A	8,520
		NOT COMPETED UNDER SIMP ACQ PROC			
			DOLB07XG20428	THE ATTORNEY GENERAL PA OFFICE OF	350
			DOLB07XG20498	INTERNATIONAL TACTICAL PRODUCTS INC	1,318
			DOLB07XG20522	WOODS PEACOCK ENGINEERING CONSULTAN	1,830
	OSHA	FOLLOW ON TO COMPETED			
			DOL07HF20149	MERRITT MAILING SYSTEMS INC	449
			DOLB069F23977	HCI ATL LIMITED LIABILITY COMPANY	605,000
			DOLB069F23980	HCI ATL LIMITED LIABILITY COMPANY	40,524
			DOLB079F25883	HCI ATL LIMITED LIABILITY COMPANY	130,000
			DOLB079F25978	EASTERN RESEARCH GROUP INCORPORATED	79,999
			DOLB07DF20956	K & D COMMUNICATIONS, INC.	3,348
			DOLB07DF20966	CHAMPION AWARDS TROPHIES & GOODS, I	3,800
			DOLB07DF20969	DAVID A HOBBS INC	4,000
			DOLB07FF21025	TASCOSA OFFICE MACHINES, INC.	2,700
			DOLB07FF21026	OCE NORTH AMERICA, INC	1,775
			DOLB07FF21043	OCE NORTH AMERICA, INC	2,192
			DOLB07FF21046	IKON OFFICE SOLUTIONS	3,001
			DOLB07FF21052	CANON USA INC	6,603
			DOLB07FF21054	SPRINT SPECTRUM L P.	3,600
			DOLB07FF21057	BLACK BOX NETWORK SERVICES INC-GOVE	1,493
			DOLB07FF21094	PITNEY BOWES INC	1,002
			DOLB07FF21095	SKYTEL CORP	1,202
			DOLB07FF21097	NATIONAL FIRE PROTECTION ASSOCIATIO	2,000
			DOLB07FF21104	CUMMINS-ALLISON CORP	488
			DOLB07FF21120	BLACK BOX NETWORK SERVICES INC-GOVE	2,102
			DOLB07FF21121	NEW CINGULAR WIRELESS NATIONAL ACCO	4,295
			DOLB07FF21122	OCE NORTH AMERICA, INC	8,631
			DOLB07FF21123	EL PASO TRIAD INC	1,152
			DOLB07FF21131	SAFETY SHOE DISTRIBUTORS, LLP	960
			DOLB07FF21133	SOUTHWESTERN BELL TELEPHONE LP	600
			DOLB07FF21135	GENERAL SERVICES ADMINISTRATION GRE	6,117
			DOLB07FF21136	BLACK BOX NETWORK SERVICES INC-GOVE	1,246
			DOLB07FF21137	BLACK BOX GOVERNMENT SOLUTIONS	2,492
			DOLB07FF21139	CINGULAR WIRELESS, LLC	38,798
			DOLB07FF21143	PITNEY BOWES GOVERNMENT SOLUTIONS,	220
			DOLB07FF21157	CINGULAR WIRELESS, LLC	545
			DOLB07FF21161	PITNEY BOWES INC	2,866
			DOLB07FF21163	SOUTH CENTRAL COMMUNICATIONS CORPOR	1,556
			DOLB07FF21176	PITNEY BOWES GOVERNMENT SOLUTIONS,	526
			DOLB07FF21177	ARCH WIRELESS OPERATING COMPANY	575
			DOLB07FF21178	GENERAL SERVICES ADMINISTRATION GRE	4,000
			DOLB07FF21179	KONICA MINOLTA BUSINESS SOLUTIONS U	1,314
			DOLB07FF21181	SUMNER GROUP INC	2,844
			DOLB07FF21184	CLASSIC COPIERS, INC	2,400
			DOLB07FF21186	GENERAL SERVICES ADMINISTRATION GRE	5,054
			DOLB07FF21189	PITNEY BOWES INC	1,884
			DOLB07FF21191	PITNEY BOWES	890
			DOLB07FF21194	NEW CINGULAR WIRELESS NATIONAL ACCO	700
			DOLB07FF21196	SOUTHWESTERN BELL TELEPHONE, L.P.	9,567
			DOLB07FF21209	SOUTHWESTERN BELL TELEPHONE, L.P.	7,500
			DOLB07FF21211	PIPKIN CAMERAS & VIDEO	1,200
			DOLB07FF21212	PITNEY BOWES INC.	432
			DOLB07FF21213	COX OKLAHOMA TELCOM, LLC	198
			DOLB07FF21214	PITNEY BOWES GOVERNMENT SOLUTIONS,	676
			DOLB07FF21215	CLASSIC COPIERS, INC	2,400
			DOLB07FF21217	DORMAN COMMUNICATIONS INC	450
			DOLB07FF21224	ARKANSAS DEMOCRAT GAZETTE, INC.	132
			DOLB07FF21225	PITNEY BOWES INC.	825

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07FF21230	LRP PUBLICATIONS INC	43
		DOLB07FF21237	SOUTHWESTERN BELL TELEPHONE LIMITED	781
		DOLB07FF21239	DAVID A HOBBS INC	2,500
		DOLB07FF21245	NATIONAL CAPITAL FLAG CO INC	2,500
		DOLB07FF21246	CANON U S A, INC	4,365
		DOLB07FF21248	SOUTHWESTERN BELL TELEPHONE, L.P.	940
		DOLB07FF21255	SOUTHWESTERN BELL TELEPHONE, L.P.	1,200
		DOLB07FF21257	SUMNER GROUP INC	4,220
		DOLB07FF21260	TELE-INTERPRETERS ON-CALL, INC.	2,000
		DOLB07FF21280	FLIGHT SUITS	30,129
		DOLB07FF21283	CINGULAR WIRELESS, LLC	540
		DOLB07FF21292	CINGULAR WIRELESS, LLC	0
		DOLB07FF21297	ENGINEERED PERFORMANCE SOLUTIONS	2,000
		DOLB07FF21315	PITNEY BOWES INC.	804
		DOLB07FF21318	PITNEY BOWES, INC.	292
		DOLB07FF21330	IKON OFFICE SOLUTIONS, INC	319
		DOLB07FF21333	OCE NORTH AMERICA, INC	1,213
		DOLB07FF21340	ALLEGIANCE TELECOM, INC.	1,200
		DOLB07FF21341	SOUTHWESTERN BELL TELEPHONE LIMITED	1,200
		DOLB07FF21353	PITNEY BOWES INC	2,736
		DOLB07FF21355	LEASE SERVICING CENTER, INC	2,782
		DOLB07FF21356	PITNEY BOWES INC	2,736
		DOLB07FF21357	LITTLEPAGE OPTICAL COMPANY	3,400
		DOLB07FF21361	SUMNER GROUP INC	711
		DOLB07FF21364	DORMAN COMMUNICATIONS INC	1,932
		DOLB07FF21368	NEXTEL PARTNERS OPERATING CORP	1,220
		DOLB07FF21369	GLOBAL OPERATIONS TEXAS LP	1,475
		DOLB07FF21413	RED WING SHOE STORES LLC	3,060
		DOLB07HF20148	HASLER, INC.	672
		DOLB07HF20149	MERRITT MAILING SYSTEMS INC	673
		DOLB07HF20150	ALL COPY PRODUCTS LLC	4,026
		DOLB07HF20151	CELLCO PARTNERSHIP DBA VERIZON WIRE	372
		DOLB07HF20152	METROCALL, INC	185
		DOLB07HF20154	CELLCO PARTNERSHIP DBA VERIZON WIRE	1,508
		DOLB07HF20169	QWEST GOVERNMENT SERVICES, INC.	1,730
		DOLB07HF20172	DIALOG CORPORATION, THE	480
		DOLB07HF20173	INFOUSA/AMERICAN BUSINESS INFORMATI	2,995
		DOLB07HF20182	PROGRAM SUPPORT CENTER	1,073
		DOLB07HF20185	CELLCO PARTNERSHIP DBA VERIZON WIRE	3,405
		DOLB07HF20188	FIRESIDE OFFICE PRODUCTS INC	175
		DOLB07HF20189	HASLER, INC.	486
		DOLB07HF20190	GENERAL SERVICES ADMINISTRATION GRE	18,800
		DOLB07HF20191	J&H OFFICE EQUIPMENT	630
		DOLB07HF20192	ALL COPY PRODUCTS LLC	7,759
		DOLB07HF20193	METROCALL	878
		DOLB07HF20194	CELLCO PARTNERSHIP DBA VERIZON WIRE	1,999
		DOLB07HF20205	PITNEY BOWES INC	624
		DOLB07HF20209	ALL COPY PRODUCTS LLC	2,676
		DOLB07HF20210	CELLCO PARTNERSHIP DBA VERIZON WIRE	296
		DOLB07HF20212	CELLCO PARTNERSHIP DBA VERIZON WIRE	284
		DOLB07HF20214	METROCALL, INC	53
		DOLU079F26071	TECHNICAL MANAGEMENT SERVICES	27,499
		DOLU069F24196	USER TECHNOLOGY ASSOCIATES, IN	57,512
		DOLU069F24197	USER TECHNOLOGY ASSOCIATES, IN	159,648
		DOLU069F24229	USER TECHNOLOGY ASSOCIATES, IN	112,800
		DOLU079F24855	EASTERN RESEARCH GROUP, INC.	49,997
		DOLU079F24990	VERTEX SOLUTIONS INC	22,995
		DOLU079F25369	USER TECHNOLOGY ASSOCIATES, IN	124,355
		DOLU079F25370	USER TECHNOLOGY ASSOCIATES, IN	103,104
		DOLU079F25676	USER TECHNOLOGY ASSOCIATES, IN	105,903
		DOLU079F25677	USER TECHNOLOGY ASSOCIATES, IN	40,638
		DOLU079F25940	EASTERN RESEARCH GROUP, INC.	2,100
		DOLU079F26055	EASTERN RESEARCH GROUP, INC.	3,100

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		NON-COMPETITIVE DELIVERY ORDER		
		DOLB069F22758	ORACLE CORPORATION	751,502
		DOLB069F23886	NEWTEK INTERNATIONAL, INC.	1,243,159
		DOLB079F24574	CIPHER SYSTEMS LIMITED LIABILITY CO	113,896
		DOLB079F24728	EASTERN RESEARCH GROUP INCORPORATED	524,092
		DOLB079F24733	EASTERN RESEARCH GROUP INCORPORATED	213,149
		DOLB079F24754	EASTERN RESEARCH GROUP INCORPORATED	122,000
		DOLB079F24849	KEYLOGIC SYSTEMS INCORPORATED	10,643
		DOLB079F25683	CIPHER SYSTEMS LIMITED LIABILITY CO	120,000
		DOLB079F26137	EASTERN RESEARCH GROUP INCORPORATED	69,938
		DOLB079F26180	CIPHER SYSTEMS LIMITED LIABILITY CO	25,000
		DOLF05DF21229	NIKON INC	6,345
		DOLF069F24556	EC AMERICA, INC.	71,871
		DOLF06E620853	OCE NORTH AMERICA, INC	9,214
		DOLF079F20720	XEROX CORPORATION	32,759
		DOLF079F24741	CONVERGENCE TECHNOLOGY CONSULTING L	18,884
		DOLF079F24897	RICOH CORPORATION	8,160
		DOLF079F24955	GOVERNMENT TECHNOLOGY SOLUTION	48,093
		DOLF079F25008	DUN & BRADSTREET INC	26,613
		DOLF079F25111	EBSCO INDUSTRIES, INC	93,017
		DOLF079F25273	WATERS TECHNOLOGIES INC.	6,870
		DOLF079F25851	FIRST FEDERAL CORPORATION	5,501
		DOLF079F25915	IMMIXTECHNOLOGY INC	75,194
		DOLF079F26108	CINGULAR WIRELESS LLC	9,880
		DOLF07DF20904	XEROX CORPORATION	30,708
		DOLF07DF20910	XEROX CORPORATION	17,391
		DOLF07DF20940	BLACK BOX CORPORATION OF PENNS	3,288
		DOLF07E620853	OCE NORTH AMERICA, INC	9,214
		DOLF07E620957	MLINQS, LLC	58,435
		DOLF07EF20739	CITRIX SYSTEMS, INC.	11,750
		DOLF07EF20857	PITNEY BOWES INC	924
		DOLF07EF20858	PITNEY BOWES INC	900
		DOLF07EF20873	RICOH CORPORATION	2,659
		DOLF07EF20883	DUN & BRADSTREET INC	4,900
		DOLF07EF20890	GYRUS SYSTEMS LC	35,456
		DOLF07EF20899	XEROX CORPORATION	2,107
		DOLF07EF20902	NCS PEARSON INC	2,329
		DOLF07EF20946	PITNEY BOWES INC	0
		DOLF07EF20958	RICOH CORPORATION	1,908
		DOLF07EF20975	LANGUAGE LINE, LLC	3,301
		DOLF07EF20985	CANON U.S.A., INC	6,281
		DOLF07EF20986	CANON U.S.A., INC	4,526
		DOLF07EF20993	SHARP ELECTRONICS CORPORATION	4,174
		DOLF07EF20995	PITNEY BOWES INC	900
		DOLF07EF20997	XEROX CORPORATION	58,970
		DOLF07EF20998	XEROX CORPORATION	74,435
		DOLF07EF21000	XEROX CORPORATION	9,153
		DOLF07EF21062	GYRUS SYSTEMS LC	1,500
		DOLF07EF21068	PITNEY BOWES INC	900
		DOLF07EF21094	DELL MARKETING LIMITED PARTNERSHIP	40,324
		DOLF07EF21110	CANON U.S.A., INC	6,152
		DOLF07EF21131	DELL MARKETING LIMITED PARTNERSHIP	11,699
		DOLF07EF21164	NCS PEARSON INC	2,100
		DOLF07EF21187	QUEST TECHNOLOGIES, INC.	29,472
		DOLF07EF21188	MINE SAFETY APPLIANCES COMPANY	70,350
		DOLF07EF21196	DRAEGER SAFETY, INC.	43,819
		DOLF07EF21202	INDUSTRIAL SCIENTIFIC CORPORAT	5,482
		DOLF07EF21203	QUEST TECHNOLOGIES, INC.	52,866
		DOLF07EF21205	SKC, INC.	42,591
		DOLF07EF21210	TECHNICAL COMMUNITIES INCORPORATED	17,898
		DOLF07EF21220	TECHNICAL COMMUNITIES INCORPORATED	39,875
		DOLF07EF21223	AGILENT TECHNOLOGIES INC	9,960
		DOLF07EF21224	BRUEL & KJAER NORTH AMERICA	4,292

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLF07EF21243	SKC, INC.	15,007
		DOLF07EF21244	VIDEO & TELECOMMUNICATIONS INC	12,915
		DOLF07EF21246	DELL MARKETING LIMITED PARTNERSHIP	33,650
		DOLF07EF21248	SUB-AQUATICS, INC	8,654
		DOLF07EF21250	MINE SAFETY APPLIANCES COMPANY	7,054
		DOLF07EF21253	DRAEGER SAFETY, INC.	9,078
		DOLF07EF21261	WATERS TECHNOLOGIES INC.	13,879
		DOLF07EF21263	SKC, INC.	62,259
		DOLF07FF21197	USER TECHNOLOGY ASSOCIATES, IN	552,027
		DOLF07FF21265	DELL MARKETING LIMITED PARTNERSHIP	8,786
		DOLF07FF21269	DELL MARKETING LIMITED PARTNERSHIP	17,891
		DOLF07FF21270	PITNEY BOWES INC	1,971
		DOLF07FF21282	SHARP ELECTRONICS CORPORATION	438
		DOLF07HF20202	PITNEY BOWES INC	364
		DOLF07JF20326	HAWORTH, INCORPORATED	67,483
		DOLU079F25416	ANCON GROUP, LLC	138,380
	NOT AVAILABLE FOR COMPETITION	DOLB079625081	FEDERAL EMPLOYEE EDUCATION AND ASSI	50,450
		DOLB079F24808	BLUE RIDGE LIMOSNE & TOURS SERVICES	6,480
		DOLB079F24837	AMERICAN INDUSTRIAL HYGIENE ASSOCIA	8,800
		DOLB079F24963	BLUE RIDGE LIMOSNE & TOURS SERVICES	5,760
		DOLB079F24974	GLOBAL TECH INC	130,867
		DOLB079F25128	YANCY & ASSOCIATES INC	10,530
		DOLB079F25252	BRUKER AXS INC	9,000
		DOLB079F25398	WATERS CORPORATION	7,665
		DOLB079F25648	ATPS INC	8,850
		DOLB079F25783	COUNTERTRADE PRODUCTS, INC.	6,107
		DOLB079F25827	HITACHI HIGH TECHNOLOGIES AMERICA I	21,850
		DOLB079F25835	COZA, INC.	25,889
		DOLB079F25919	TKC INTEGRATION SERVICES LLC	45,829
		DOLB079F26093	COPPER RIVER INFORMATION TECHNOLOGY	18,856
		DOLB079F26235	PANAMERICA COMPUTERS INC	171,153
		DOLB07D620889	BOWE BELL & HOWELL COMPANY	14,446
		DOLB07EF20897	UNIVERSITY OF CINCINNATI	13,280
		DOLB07EF20971	NICK PACALO	6,338
		DOLB07EF21021	TRAINING ASSOCIATES	2,893
		DOLB07EF21039	HILTON GARDEN INN	3,700
		DOLB07EF21045	NICOLAS PACALO	7,156
		DOLB07EF21046	ROCKFORD SYSTEMS, INC.	3,000
		DOLB07EF21048	JAMES ZUCCHERO & ASSOCIATES INC.	7,725
		DOLB07EF21049	JAMES ZUCCHERO & ASSOCIATES INC.	5,698
		DOLB07EF21051	GERALD V. MILLER ASSOCIATES	8,639
		DOLB07EF21061	FRAZIER & ASSOCIATES INC	5,045
		DOLB07EF21076	NICOLAS PACALO	5,568
		DOLB07EF21090	VAC U STRIP INC.	8,239
		DOLB07EF21102	COMMUNITY ISSUES CONSULTANTS & ASSO	17,298
		DOLB07EF21123	JAMES ZUCCHERO & ASSOCIATES INC.	6,876
		DOLB07EF21136	CODY SMITH	3,555
		DOLB07EF21149	LAURA GREENE & ASSOCIATES	8,369
		DOLB07EF21150	THERMAL CUTTING CONSULTING INC	2,903
		DOLB07EF21154	NICOLAS PACALO	5,575
		DOLB07EF21155	CODY SMITH	4,872
		DOLB07EF21169	C & I SAFETY CONSULTING	5,982
		DOLB07EF21181	HOLIDAY INN MINNEAPOLIS METRODOME	58,969
		DOLB07EF21195	EMBASSY SUITES SCHAUMBURG	8,112
		DOLB07EF21200	TMK & ASSOCIATES INC	9,965
		DOLJ079F26354	CAPITOL CREAM, LLC	216,603
		DOLU079F25416	ANCON GROUP, LLC	138,380
		DOLU079F25941	EASTERN RESEARCH GROUP, INC.	2,700
		DOLU079F26272	USER TECHNOLOGY ASSOCIATES, IN	8,750
		DOLU079F26593	UNIVERSITY OF CINCINNATI	8,550
	NOT COMPETED	DOLB06AF20304	GRAYBOY, INC.	4,100
		DOLB06HF20139	DAVID J. COCHRAN	10,000

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB079F24605	PANAMERICA COMPUTERS INC	24,385
		DOLB079F24688	H E I HOSPITALITY LLC	21,088
		DOLB079F24689	ACCESS INTELLIGENCE, LLC	17,950
		DOLB079F24695	TRUSTEES OF COLUMBIA UNIVERSITY IN	3,000
		DOLB079F24892	PERKINELMER LAS, INC	4,000
		DOLB079F24898	NEO TECH SOLUTIONS INC	928,775
		DOLB079F24945	KNORR ASSOCIATES INC	5,141
		DOLB079F25235	NACIO SYSTEMS, INC	16,250
		DOLB079F25445	RIGAKU AMERICAS CORPORATION	21,150
		DOLB079F25511	AMERICAN SOCIETY OF SAFETY ENGINEER	4,400
		DOLB079F25777	NUCLEAR REGULATORY COMMISSION, UNIT	2,900
		DOLB079F25811	ALLIANCE TECHNOLOGY GROUP LLC	12,599
		DOLB07AF20375	ROBERT G ZALOSH	11,000
		DOLB07AF20443	NATIONAL FIRE PROTECTION ASSOCIATIO	6,278
		DOLB07DF21299	DOMBROWSKI FORENSIC ENGINEERS, PA	20,849
		DOLB07E320875	RICOH BUSINESS SYSTEMS	3,383
		DOLB07E320900	CINCINNATI BELL TELEPHONE COMPANY	3,408
		DOLB07E620959	MERLIN DICKHANS	300
		DOLB07E621133	DELL FEDERAL SYSTEMS GP LLC	4,304
		DOLB07EE20922	AMERICAN COPY EQUIPMENT	10,284
		DOLB07EE20923	CANON BUSINESS SOLUTIONS-CENTRAL, I	428
		DOLB07EF20741	TREEHOUSE SOFTWARE INC	5,800
		DOLB07EF20859	PITNEY BOWES	987
		DOLB07EF20860	PITNEY BOWES	908
		DOLB07EF20862	WIRE ONE COMMUNICATIONS, INC	12,534
		DOLB07EF20865	CANON BUSINESS SOLUTIONS-CENTRAL, I	1,574
		DOLB07EF20866	CANON BUSINESS SOLUTIONS-CENTRAL, I	3,133
		DOLB07EF20867	CANON BUSINESS SOLUTIONS-CENTRAL, I	1,157
		DOLB07EF20868	CANON BUSINESS SOLUTIONS-CENTRAL, I	3,890
		DOLB07EF20876	MODERN BUSINESS MACHINES	365
		DOLB07EF20889	LIGHTHOUSE SAFETY, LLC	3,450
		DOLB07EF20891	SMG SECURITY SYSTEMS INC	2,280
		DOLB07EF20894	INITIAL ELECTRONICS, INC	2,400
		DOLB07EF20898	UNITED VISUAL INC	15,600
		DOLB07EF20901	CRYSTAL CITY COURTYARD BY MARRIOTT	4,197
		DOLB07EF20911	BRIGHT INSIGHT COMPUTER INSTRUCTION	1,980
		DOLB07EF20913	SCANTRON SERVICE GROUP	896
		DOLB07EF20914	MIDCO, INC.	7,002
		DOLB07EF20915	NEOPOST INC.	5,225
		DOLB07EF20916	ROCKY MOUNTAIN EDUCATION CENTER	2,400
		DOLB07EF20936	SAFWAY SERVICES INC	3,460
		DOLB07EF20937	GERALD V. MILLER ASSOCIATES	8,440
		DOLB07EF20940	UNITED BROTHERHOOD OF CARPENTER AND	4,500
		DOLB07EF20952	MILLER RESEARCH AND TRAINING OPTION	1,200
		DOLB07EF20954	CENTAURUS TECHNOLOGY INC	2,984
		DOLB07EF20956	NPM ENVIRONMENTAL & SAFETY INC.	6,792
		DOLB07EF20964	WANGER CONSULTING	5,041
		DOLB07EF20966	EDGWATER HOTEL	900
		DOLB07EF20970	ACUTECH CONSULTING GROUP	3,909
		DOLB07EF20972	JOHN SAKASH CO INC	700
		DOLB07EF20973	LIGHTHOUSE SAFETY, LLC	843
		DOLB07EF20974	RZP INTERNATIONAL LTD	4,114
		DOLB07EF20989	J M CHOLIN CONSULTANTS INC	8,000
		DOLB07EF20990	GORDON FLESH COMPANY INC	235
		DOLB07EF20992	OFFICE COPYING EQUIPMENT LTD	922
		DOLB07EF20996	C & B ENTERPRISES	14,000
		DOLB07EF21006	LASALLE REPORTING SERVICE LTD	455
		DOLB07EF21007	MIDCO, INC.	309
		DOLB07EF21010	CENTAURUS TECHNOLOGY INC	3,341
		DOLB07EF21011	ACUTECH CONSULTING GROUP	7,016
		DOLB07EF21013	LASALLE REPORTING SERVICE LTD	816
		DOLB07EF21014	DESKS, INC.	3,515
		DOLB07EF21015	PITNEY BOWES	2,326

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07EF21027	CHICAGOLAND LABORS TRAINING FUND	1,200
		DOLB07EF21029	WANGER CONSULTING	3,444
		DOLB07EF21030	CHILWORTH TECHNOLOGY INC	3,185
		DOLB07EF21031	SHERATON DENVER WEST	750
		DOLB07EF21032	MVH AMERICAS, INC.	3,855
		DOLB07EF21033	FREDRICK T ELDER & ASSOCIATES	8,509
		DOLB07EF21034	JAMES WASHAM	5,579
		DOLB07EF21044	JAMES WASHAM	300
		DOLB07EF21052	GERALD V. MILLER ASSOCIATES	5,588
		DOLB07EF21053	MIKE HARTZ	2,100
		DOLB07EF21054	MORaine VALLEY COMMUNITY COLLEGE	500
		DOLB07EF21055	OCCUPATIONAL RISK SOLUTIONS	4,500
		DOLB07EF21058	UNITED VISUAL INC	15,850
		DOLB07EF21064	SYSTEMS APPROACH LTD	3,780
		DOLB07EF21065	CHICAGOLAND LABORS TRAINING FUND	400
		DOLB07EF21067	FIRECON	5,650
		DOLB07EF21070	SAFWAY SERVICES INC	3,460
		DOLB07EF21071	HASSELBRING CLARK COMPANY	1,505
		DOLB07EF21073	PITNEY BOWES	587
		DOLB07EF21077	STAR OF AMERICA LLC	491
		DOLB07EF21079	DILLON'S BUS SERVICE, INC	710
		DOLB07EF21080	NPM ENVIRONMENTAL & SAFETY INC.	4,192
		DOLB07EF21082	FREDRICK T ELDER & ASSOCIATES	5,943
		DOLB07EF21083	CHILWORTH TECHNOLOGY INC	3,552
		DOLB07EF21085	L P R CONSTRUCTION CO	1,228
		DOLB07EF21086	SAFWAY SERVICES INC	3,460
		DOLB07EF21087	LARRY ALEKSANDRICH	2,931
		DOLB07EF21087	CRANE INSTITUTE OF AMERICA	3,951
		DOLB07EF21091	CROSBY GROUP INC	500
		DOLB07EF21092	MORaine VALLEY COMMUNITY COLLEGE	500
		DOLB07EF21096	MILLER RESEARCH AND TRAINING OPTION	1,000
		DOLB07EF21097	NIHS INC	2,100
		DOLB07EF21100	COM-TECH CONSTRUCTION, INC.	1,500
		DOLB07EF21101	MALTER ASSOCIATES, INC	3,134
		DOLB07EF21105	SAFE-CON LLC	1,130
		DOLB07EF21107	FIREXPLO	10,000
		DOLB07EF21111	JAMES WASHAM	2,700
		DOLB07EF21115	CENTAURUS TECHNOLOGY INC	2,252
		DOLB07EF21118	ACUTECH CONSULTING GROUP	5,123
		DOLB07EF21119	SAFETY HEALTH AND ENVIRONMENTAL SE	1,325
		DOLB07EF21121	RIMAGE CORPORATION	7,911
		DOLB07EF21122	DH GLABE & ASSOCIATES, INC.	5,601
		DOLB07EF21125	LIGHTHOUSE SAFETY, LLC	843
		DOLB07EF21127	L P R CONSTRUCTION CO	1,228
		DOLB07EF21128	DONOVAN GRENZ AND ASSOCIATES	5,602
		DOLB07EF21130	MVH AMERICAS, INC.	4,650
		DOLB07EF21132	NCS PEARSON, INC.	3,603
		DOLB07EF21134	VODIUM INC	2,500
		DOLB07EF21135	MORaine VALLEY COMMUNITY COLLEGE	500
		DOLB07EF21137	CHILWORTH TECHNOLOGY INC	3,235
		DOLB07EF21138	FREDRICK T ELDER & ASSOCIATES	5,954
		DOLB07EF21143	SMITH & BURGESS LLC	5,821
		DOLB07EF21144	FRAZIER & ASSOCIATES INC	4,048
		DOLB07EF21145	ENMET CORPORATION	995
		DOLB07EF21146	THYSSENKRUPP SAFWAY SERVICES INC	3,409
		DOLB07EF21156	CENTAURUS TECHNOLOGY INC	2,252
		DOLB07EF21162	ACUTECH CONSULTING GROUP	2,865
		DOLB07EF21163	NPM ENVIRONMENTAL & SAFETY INC.	5,991
		DOLB07EF21166	SMITH & BURGESS LLC	5,821
		DOLB07EF21171	JAMES WASHAM	2,558
		DOLB07EF21173	DONOVAN GRENZ AND ASSOCIATES	4,025
		DOLB07EF21174	COM-TECH CONSTRUCTION, INC.	1,500
		DOLB07EF21177	4-SAFETY, LLC	3,800

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FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07EF21178	MANAGEMENT CONSULTING ASSOCIATES	13,890
		DOLB07EF21185	CHICAGOLAND LABORS TRAINING FUND	1,200
		DOLB07EF21186	BIOHAZTEC ASSOCIATES INC	1,775
		DOLB07EF21206	QUEST TECHNOLOGIES, INC.	24,575
		DOLB07EF21208	JAMES WASHAM	2,400
		DOLB07EF21209	MANAGEMENT CONSULTING ASSOCIATES	2,500
		DOLB07EF21211	MILLER RESEARCH AND TRAINING OPTION	2,475
		DOLB07EF21213	DRAEGER SAFETY, INC.	8,124
		DOLB07EF21216	ETS-LINDGREN LP	9,475
		DOLB07EF21217	BRUEL & KJAER NORTH AMERICA	23,574
		DOLB07EF21218	AUDIO PRECISION INC	6,370
		DOLB07EF21219	VAL-FLO CONTROLS INC	19,925
		DOLB07EF21222	LANDAUER, INC.	16,400
		DOLB07EF21226	SPEX SAMPLEPREP LLC	5,830
		DOLB07EF21228	FIREXPLO	1,000
		DOLB07EF21229	CLAPP RESEARCH ASSOCIATES P C	10,000
		DOLB07EF21235	RESPONSE BIOMEDICAL CORP	15,900
		DOLB07EF21238	INFRARED SYSTEMS INC	2,500
		DOLB07EF21241	QUEST TECHNOLOGIES, INC.	24,600
		DOLB07EF21247	THERMO NITON ANALYZERS LLC	24,995
		DOLB07FF21042	PITNEY BOWES INC	216
		DOLB07FF21045	SOUTHWESTERN BELL TELEPHONE	5,625
		DOLB07FF21096	INFORMATION HANDLING SERVICES INC	2,000
		DOLB07FF21099	FEDERAL EMPLOYEES NEWS DIGEST INC	130
		DOLB07FF21229	IRON AGE CORPORATION	840
		DOLB07FF21261	STEVENS PUBLISHING CORPORATION	399
		DOLB07FF21266	THOMSON SCIENTIFIC INC	2,000
		DOLB07FF21267	OAG WORLDWIDE INC	599
		DOLB07FF21268	CHAMPION AWARDS TROPHIES & GOODS, I	2,500
		DOLB07FF21275	SOUTH CENTRAL COMMUNICATIONS CORP	2,400
		DOLB07FF21306	GENERAL SERVICES ADMINISTRATION GRE	2,936
		DOLB07FF21478	HURST METALLURGICAL RESEARCH LABORA	6,000
		DOLB07FF21491	J M CHOLIN CONSULTANTS INC	13,863
		DOLB07GF20200	AVAYA COMMUNICATIONS	2,010
		DOLB07GF20202	APCOA/STANDARD PARKING	1,320
		DOLB07GF20203	PANASONIC DOCUMENT IMAGING COMPANY	4,458
		DOLB07GF20204	PANASONIC DOCUMENT IMAGING COMPANY	3,283
		DOLB07GF20205	PANASONIC DOCUMENT IMAGING COMPANY	5,513
		DOLB07GF20206	PANASONIC DOCUMENT IMAGING COMPANY	1,401
		DOLB07GF20207	DANKA HOLDING COMPANY PARENT COMPAN	1,387
		DOLB07GF20210	NEXTIRAONE FEDERAL, LLC	2,740
		DOLB07GF20211	AVAYA COMMUNICATIONS	1,684
		DOLB07GF20222	GRAY, PATRICIA A	1,400
		DOLB07GF20224	LINKYO CORP	3,750
		DOLB07GF20230	AVAYA COMMUNICATIONS	1,684
		DOLB07GF20231	AVAYA COMMUNICATIONS	1,372
		DOLB07GF20237	DANKA OFFICE IMAGING	416
		DOLB07GF20241	GRAY, PATRICIA A	450
		DOLB07GF20256	DONAHUE, JOHN J	4,100
		DOLB07GF20257	HOTEL PHILLIPS INC	1,863
		DOLB07GF20258	HOTEL PHILLIPS INC	2,784
		DOLB07GF20266	SPACES, INC	3,956
		DOLB07GF20281	VOICEPRO, INC	24,999
		DOLB07GF20282	BRADLEY'S TELECOM SOLUTIONS	2,325
		DOLB07GF20284	QUINN'S QUALITY REPORTING LTD	1,515
		DOLB07HF20145	STATE OF MONTANA	950
		DOLB07HF20146	QWEST CORPORATION	120
		DOLB07HF20157	CINGULAR WIRELESS, LLC	1,500
		DOLB07HF20171	MUZAK, LLC	816
		DOLB07HF20178	ANDERSON, BARBARA	594
		DOLB07HF20197	LIBRARY OF CONGRESS	5,926
		DOLB07HF20221	COLORADO NETWORK STAFFING INC	15,900
		DOLB07HF20230	REPORTER BIG SKY OFFICE, INC	2,780

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency	CONTRACT NUMBER	CONTRACTOR	Total \$
		DOLB07HF20231	THE HON COMPANY	14,700
		DOLB07JF20241	GUAM TELEPHONE AUTHORITY	7,080
		DOLB07JF20245	GUAM TELEPHONE AUTHORITY	16,000
		DOLJ079F25236	DIONEX CORPORATION	5,000
		DOLJ079F25237	PERKINELMER LAS INCORPORATED	20,000
		DOLJ079F25275	RANDOM, WAYNE	25,300
		DOLJ079F26135	MINE SAFETY APPLIANCES COMPANY	25,000
		DOLU079F26271	USER TECHNOLOGY ASSOCIATES, IN	9,256
		DOLU079F26274	USER TECHNOLOGY ASSOCIATES, IN	18,312
	NOT COMPETED UNDER SIMP ACQ PROC	DOLB07AF20328	SYSTEMATICS, INC.	2,400
		DOLB07AF20330	CHARTER OAK SQUARE LP	2,340
		DOLB07AF20379	MARRIOTT INTERNATIONAL, INC	246
		DOLB07AF20393	MARRIOTT INTERNATIONAL, INC	306
		DOLB07AF20395	MARRIOTT INTERNATIONAL, INC	480
		DOLB07AF20396	FAIRFIELD INN & SUITES	160
		DOLB07AF20397	KENNEBEC YACHT CLUB	320
		DOLB07AF20399	MARRIOTT INTERNATIONAL, INC	276
		DOLB07AF20406	EXIT 88 HOTEL LLC	216
		DOLB07AF20411	MARRIOTT INTERNATIONAL, INC	759
		DOLB07AF20412	RCN CORPORATION	502
		DOLB07AF20414	MARRIOTT INTERNATIONAL, INC	605
		DOLB07AF20417	MARRIOTT INTERNATIONAL, INC	192
		DOLB07AF20435	SIMON, FRANKLIN W	200
		DOLB07AF20440	MARRIOTT INTERNATIONAL, INC	484
		DOLB07AF20450	AUDIO VISUAL SERVICES GROUP	144
		DOLB07BF20401	IKON OFFICE SOLUTIONS	1,368
		DOLB07BF20402	IKON OFFICE SOLUTIONS	950
		DOLB07BF20447	THE BUREAU OF NATIONAL AFFAIRS INC	784
		DOLB07BF20448	TELE-INTERPRETERS ON-CALL, INC.	2,000
		DOLB07BF20455	COMMUNITY DISTRIBUTORS INC	1,320
		DOLB07BF20456	ARCH WIRELESS OPERATING COMPANY	1,320
		DOLB07BF20457	ECHOSTAR COMMUNICATIONS CORPORATION	738
		DOLB07BF20459	IKON OFFICE SOLUTIONS	2,208
		DOLB07BF20461	IKON OFFICE SOLUTIONS, INC	1,566
		DOLB07BF20462	TOSHIBA BUSINESS SOLUTIONS-NY, INC	820
		DOLB07BF20465	RICOH CORPORATION	381
		DOLB07BF20466	AMERICAN FIRE EXTINGUISHE	76
		DOLB07BF20467	IKON OFFICE SOLUTIONS	1,368
		DOLB07BF20472	IKON OFFICE SOLUTIONS	2,420
		DOLB07BF20474	IKON OFFICE SOLUTIONS	1,404
		DOLB07BF20475	IKON OFFICE SOLUTIONS	2,496
		DOLB07BF20477	RICOH CORPORATION	1,500
		DOLB07BF20479	IKON OFFICE SOLUTIONS	2,400
		DOLB07BF20485	TRUMP PLAZA ASSOCIATES, A N.J. GENE	500
		DOLB07BF20486	WESTCHESTER, COUNTY OF	250
		DOLB07BF20487	DINOSAUR BAR & CHAR INC	726
		DOLB07BF20488	ANTONEES GOURMET FAMILY	1,450
		DOLB07BF20492	TELAMENITY COMMUNICATIONS	2,038
		DOLB07BF20494	HST LESSEE CMBS LLC	2,030
		DOLB07BF20495	PREMIUM ELECTRONICS & WIRELESS	280
		DOLB07BF20500	IKON OFFICE SOLUTIONS, INC.	805
		DOLB07BF20501	IKON OFFICE SOLUTIONS, INC.	950
		DOLB07BF20511	685 E 187TH STREET DELI, INC	998
		DOLB07BF20519	DE PAOLO-CROSBY REPORTING SERVICE,	500
		DOLB07BF20522	AMERICAN SOCIETY OF CIVIL ENGINEERS	1,255
		DOLB07BF20525	THE NEW JERSEY STATE SAFETY COUNCIL	994
		DOLB07BF20526	THE NEW JERSEY STATE SAFETY COUNCIL	880
		DOLB07BF20529	SAFETY CONNECTION INC	1,175
		DOLB07BF20532	SOUTH AMERICAN SPANISH ASSOCIATION	100
		DOLB07BF20533	RESEARCH COMMUNICATIONS INC.	615
		DOLB07BF20535	ADVANCED DIGITAL COMMUNICATIONS COR	2,417

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLB07BF20539	MODERN OFFICE SYSTEMS INC	75
			DOLB07BF20557	SPA HOTEL II, LLC	1,866
			DOLB07BF20586	DATICON, LLC A XIOTECH COMPANY	8,100
			DOLB07BF20588	NATIONAL SAFETY COUNCIL	540
			DOLB07BF20589	A J EQUIPMENT CORPORATION	288
			DOLB07BF20603	WALDNER BUSINESS ENVIRONMENTS INC	1,104
			DOLB07BF20604	DOLAN, JEAN E	2,524
			DOLB07DF20955	ADS TELECOM, INC	2,882
			DOLB07FF21012	ALLTEL CORPORATION	2,400
			DOLB07FF21329	OK TOURS	1,350
			DOLB07FF21388	PITNEY BOWES INC	750
			DOLB07FF21389	CINGULAR WIRELESS, LLC	1,350
			DOLB07FF21401	WANGER CONSULTING	10,000
			DOLB07FF21406	FEC COMMUNICATIONS LLP	1,179
			DOLB07FF21410	A T & T CORP	1,260
			DOLB07FF21421	PATTON CONTRACTORS, INC	1,235
			DOLB07FF21431	PATTON CONTRACTORS, INC	1,068
			DOLB07FF21442	THORNTON BERRY, ANN	2,000
			DOLB07HF20140	XEROX CORPORATION	396
			DOLB07HF20200	CROWNE PLAZA HOTEL	300
			DOLB07HF20213	HULM LISA REPORTING	371
			DOLB07HF20218	PROGRAM SUPPORT CENTER	1,930
			DOLB07HF20229	DH GLABE & ASSOCIATES, INC.	4,000
			DOLB07HF20277	CUSTOM ENVIRONMENTAL SERVICES, INC	2,300
			DOLB07JF20242	GUAM POWER AUTHORITY	6,000
			DOLB07JF20246	GUAM TELEPHONE AUTHORITY	10,420
	PBGC	FOLLOW ON TO COMPETED	PBGC01PO070200	SOLOMON TASHA N	34,200
		NON-COMPETITIVE DELIVERY ORDER	PBGC01DO070004	SIEMENS BUILDING TECHNOLOGIES	94,740
			PBGC01DO070008	FEDERAL EXPRESS CORPORATION	19,200
			PBGC01DO070017	PROVISTA SOFTWARE INTL, INC.	18,633
			PBGC01DO070020	EC AMERICA, INC.	51,321
			PBGC01DO070022	PROVISTA SOFTWARE INTL, INC.	8,212
			PBGC01DO070026	PVA INCORPORATED	7,316
			PBGC01DO070146	BOOZ ALLEN HAMILTON INC.	557,643
			PBGC01DO070156	MUTARE, INC.	10,277
			PBGC01DO070224	CANON U.S.A., INC	9,494
			PBGC01DO070308	GRADUATE SCHOOL, USDA	95,148
		NOT COMPETED	PBGC01CT040696	JPMORGAN CHASE BANK NATIONAL ASSOCI	90,000
			PBGC01IA060035	PROGRAM SUPPORT CENTER (1668) 15693	9,206
			PBGC01PO070013	PITNEY BOWES INCORPORATED (5050)	9,098
			PBGC01PO070088	ZANNI DAVID	6,400
			PBGC01PO070110	SHPS HUMAN RESOURCE SOLUTIONS INCOR	25,000
			PBGC01PO070146	HARVEY J LEBSON	88,400
			PBGC01PO070161	ASSOCIATION OF HISPANIC CPAS	5,000
			PBGC01PO070167	WATSON WYATT AND COMPANY	4,239
			PBGC01PO070169	WATSON WYATT AND COMPANY	4,239
			PBGC01PO070281	CYBERCHANNEL INCORPORATED	27,500
	SOL	FOLLOW ON TO COMPETED	DOLB07FN21027	NEW CINGULAR WIRELESS SERVICES, INC	988
			DOLB07FN21028	WEST PUBLISHING CORPORATION	4,653
			DOLB07FN21030	MATTHEW BENDER & COMPANY INC	3,627
			DOLB07FN21036	XEROX CORPORATION	498
		NON-COMPETITIVE DELIVERY ORDER	DOLB069N23653	BPX TECHNOLOGIES, INC.	52,724
			DOLF079N23812	XEROX CORPORATION	12,435
			DOLF079N24283	XEROX CORPORATION	15,710
			DOLF079N24363	XEROX CORPORATION	10,518
			DOLF079N25249	MATTHEW BENDER & CO INC.	13,730
			DOLF079N25264	CCH INCORPORATED	5,692
			DOLF079N25290	CCH INCORPORATED	3,267
			DOLF079N25438	WEST PUBLISHING CORPORATION	72,050

Detail Listing of Contracts with Less Than Full and Open Competition

FY	Agency		CONTRACT NUMBER	CONTRACTOR	Total \$
			DOLF079N25487	CCH INCORPORATED	4,582
			DOLF07DN21315	WEST PUBLISHING CORPORATION	10,458
			DOLF07DN21361	MATTHEW BENDER & CO INC.	3,439
			DOLF07EN20903	MATTHEW BENDER & CO INC.	3,627
			DOLF07EN20904	MATTHEW BENDER & CO INC.	2,449
			DOLF07EN20905	CCH INCORPORATED	6,877
			DOLF07EN20906	CCH INCORPORATED	5,480
			DOLF07EN20961	XEROX CORPORATION	9,099
			DOLF07EN20962	XEROX CORPORATION	6,709
			DOLF07EN21008	PITNEY BOWES INC	1,272
		NOT AVAILABLE FOR COMPETITION			
		NOT COMPETED	DOLB079N25341	B.I.G. ENTERPRISES, INC.	52,700
			DOLB079N26179	BARLING BAY LLC	9,149
			DOLB079N26316	PANAMERICA COMPUTERS INC	17,236
			DOLB079N25214	ASPEN PUBLISHERS INC	5,192
			DOLB079N25287	WILLIAM S. HEIN & CO., INC.	3,685
			DOLB079N25413	LEXISNEXIS ENTERPRISE & LIBRARY SOL	4,771
			DOLB079N26427	CONGRESSIONAL QUARTERLY, INC	17,200
			DOLB07DN21063	LASALLE REPORTING SERVICE LTD	6,343
			DOLB07EN20907	THOMSON WEST GROUP	13,990
			DOLB07EN20908	THOMSON WEST GROUP	12,298
			DOLB07FN21033	CCH INCORPORATED	5,697
			DOLB07FN21272	LRP PUBLICATIONS INC	250
			DOLB07FN21555	UNICOR FEDERAL PRISON INDUSTRIES IN	10,051
			DOLB07GN20197	IKON FINANCIAL SERVICES	9,828
			DOLB07GN20232	MATTHEW BENDER & COMPANY INC	2,600
			DOLB07GN20233	THOMSON WEST GROUP	9,972
			DOLB07GN20234	THOMSON WEST GROUP	12,415
			DOLB07GN20235	CCH INCORPORATED	5,359
			DOLB07GN20275	CREATIVE COMMUNICATION COMPANY OF FL	8,002
			DOLB07KN20106	LEXISNEXIS MATTHEW BENDER & CO INC	4,873
			DOLB07KN20154	CENTRAL COURT REPORTING	6,738
		NOT COMPETED UNDER SIMP ACQ PROC			
			DOLB07AN20418	H & C SERVICE CORPORATION	300
			DOLB07AN20422	COOPER, RICHARD A	110
			DOLB07AN20441	COOPER, RICHARD A	110
			DOLB07BN20415	CANON BUSINESS SOLUTIONS EAST INC	632
			DOLB07BN20489	PACER SERVICE CENTER	800
			DOLB07BN20524	CENTRAL PARKING SYSTEM OF NEW YORK,	1,050
			DOLB07BN20534	SHARMA, UPI	944
			DOLB07BN20551	R C OFFICE CONCEPTS INC	500
			DOLB07BN20554	LYON, MAYDA	500
			DOLB07BN20561	DEWEY PUBLICATIONS INC	2,247
			DOLB07BN20574	AWHFFY PUBLISHING L P	1,336
			DOLB07BN20577	CSN STORES, INC	438
			DOLB07BN20615	MESSINA RISO, ANNA MARIA	800
			DOLB07BN20689	BERNHARDT, ISOLINA	350
			DOLB07JN20315	ESQUIRE DEPOSITION SERVICES, LLC	8,854
	VETS	NON-COMPETITIVE DELIVERY ORDER	DOLF069524659	MANAGEMENT SUPPORT TECHNOLOGY	876,858
		NOT AVAILABLE FOR COMPETITION			
		NOT COMPETED	DOLB079524449	HEITECH SERVICES INCORPORATED	1,279,300
			DOLB079525022	SYSTEM AND INFORMATION SERVICES COR	22,175
			DOLB069624618	B.I.G. ENTERPRISES, INC.	50,960
			DOLB079525752	STLEO FILM & VIDEO LLC	16,800
			DOLB079525754	EXHIBIT PROMOTIONS PLUS INC	3,340
			DOLB079526107	U S BUSINESS LEADERSHIP NETWORK	10,000
			DOLB079526596	B.I.G. ENTERPRISES, INC.	25,480
			DOLJ079525762	PREMIER CONSULTANTS INTERNATIONAL I	150,000

CONTRACT FTE

Mr. Obey: Please provide the total number of contract FTE for each operating division and the department as a whole for fiscal years 2005, 2006, and 2007.

Ms. Chao: The Department does not keep data on contract employee usage that would allow us to develop an estimate of contract Full-Time Equivalent (FTE) as you have requested. There are many variables that would need to be considered to develop such a number, including the amount of time each contractor spends on a DOL project. If a contract is a firm fixed price, then this data would not be required to be reported. If a contract does report employee time usage data on DOL projects through contract invoices, we are not required to calculate and report a contract FTE number, nor do we currently have that capability.

CONTRACTING

Mr. Obey: Please provide the number and amount of all noncompetitive grants awarded by each operating division, and the percentage share of all such grants for the department as a whole, in each of fiscal years 2005, 2006 and 2007, excluding any Congressional earmarks. Please provide a listing of all such grants awarded in fiscal year 2007.

Ms. Chao: The table below shows number, amount, and percentage of all noncompetitive grants awarded by each operating division in fiscal year 2007.

DOL Non-Competitive Grant Awards									
2007 Obligations	By Agency								
	DOL Total	ETA	ILAB	OSHA	VETS	ODEP	MSHA	BLS	
Total Non-Competitive Grant Obligations	\$362,699,935	\$207,756,674	\$11,400,000	\$142,854,131	\$689,130	\$0	\$0	\$0	
Emergency Response Non-Competitive Grant Obligations	\$120,373,037	120,373,037	0	0	0	0	0	0	
Other DOL Non-Competitive Grant Obligations	242,326,898	87,383,637	11,400,000	142,854,131	689,130	0	0	0	
Percent Total Non-Competitive Grant	4.2%	2.5%	30.3%	92.3%	0.4%	0.0%	0.0%	0.0%	
Percent Emergency Response Non-Competitive Grant Obligations	1.4%	1.5%							0.0%
Percent DOL Non-Competitive Grant Obligations	2.8%	1.1%	30.3%	92.3%	0.4%	0.0%	0.0%	0.0%	
All Grants Obligations - NonCompetitive, Competitive, and Formula	\$8,703,516,283	\$8,243,588,838	\$37,649,398	\$154,722,986	\$164,015,034	\$4,156,066	\$11,880,352	\$87,503,609	

DOL Non-Competitive Grant Awards									
2007 Actions	By Agency								
	DOL Total	ETA	ILAB	OSHA	VETS	ODEP	MSHA	BLS	
Total Non-Competitive Grant Obligations	226	109	4	111	2	0	0	0	
Emergency Response Non-Competitive Grant Obligations	56	56							
Other DOL Non-Competitive Grant Obligations	170	53	4	111	2	0	0	0	
Percent Total Non-Competitive Grant Obligations	4.8%	3.2%	50.0%	13.7%	1.1%	0.0%	0.0%	0.0%	
Percent Emergency Response Non-Competitive Grant Obligations	1.2%	1.6%	0.0%	0.0%					
Percent DOL Non-Competitive Grant Obligations	3.6%	1.6%	50.0%	13.7%	1.1%	0.0%	0.0%	0.0%	
All Grants Obligations - NonCompetitive, Competitive, and Formula	4,684	3,400	8	812	182	2	77	203	

The table below shows amount, and percentage of all noncompetitive grants awarded by each operating division in fiscal year 2006 and fiscal year 2005.

DOL Non-Competitive Grant Obligations										
2006	By Agency									
	DOL Total	ETA	ILAB	OSHA	VETS	ODEP	MSHA	BLS		
Total Non-Competitive Grant Obligations	\$466,642,847	\$313,053,762	\$2,382,000	\$145,977,892	\$2,569,038	\$2,660,155	\$0	\$0		
Emergency Response Non-Competitive Grant Obligations	281,940,323	281,940,323	0	0	0	0	0	0		
Other DOL Non-Competitive Grant Obligations	184,702,524	31,113,439	2,382,000	145,977,892	2,569,038	2,660,155	0	0		
Obligations	5.3%	3.8%	6.6%	93.5%	1.4%	25.6%	0.0%	0.0%		
Percent Emergency Response Non-Competitive Grant Obligations	3.2%	3.4%						0.0%		
Percent DOL Non-Competitive Grant Obligations	2.1%	0.4%	6.6%	93.5%	1.4%	25.6%	0.0%	0.0%		
All Grants Obligations - NonCompetitive, Competitive, and Formula	\$8,831,149,993	\$8,339,247,501	\$35,882,000	\$156,153,161	\$189,996,000	\$10,379,338	\$7,159,974	\$92,332,019		

DOL Non-Competitive Grant Obligations										
2005	By Agency									
	DOL Total	ETA	ILAB	OSHA	VETS	ODEP	MSHA	BLS		
Total Non-Competitive Grant Obligations	\$518,036,638	\$346,975,591	\$19,630,000	\$150,907,730	\$223,650	\$299,667	\$0	\$0		
Emergency Response Non-Competitive Grant Obligations	267,348,850	267,348,850								
Other DOL Non-Competitive Grant Obligations	250,687,788	79,626,741	19,630,000	150,907,730	223,650	299,667	0	0		
Obligations	5.6%	4.0%	32.9%	96.6%	0.1%	1.3%	0.0%	0.0%		
Percent Total Non-Competitive Grant Obligations	2.9%	3.1%	0.0%	0.0%						
Percent Emergency Response Non-Competitive Grant Obligations	2.7%	0.9%	32.9%	96.6%	0.1%	1.3%	0.0%	0.0%		
All Grants Obligations - NonCompetitive, Competitive, and Formula	\$9,213,832,962	\$8,686,168,294	\$59,630,000	\$156,216,983	\$189,434,000	\$23,485,438	\$6,925,800	\$91,972,447		

The table below shows a list of all grants awarded in fiscal year 2007.

US Department of Labor FY 2007 Noncompetitive Grants		
Agency	Grantee	Total
ETA	ALABAMA DEPARTMENT OF ECONOMIC AND COMMUNITY AFFAIRS (ADECA)	1,314,096
	ARIZONA GOVERNORS OFFICE FOR CHILDREN YOUTH AND FAMILIES	114,623
	ARKANSAS DEPARTMENT OF WORKFORCE SERVICES	65,000
	CA EMPLOYMENT DEVELOPMENT DEPARTMENT	12,272,819
	CO DEPARTMENT OF LABOR & EMPLOYMENT	4,193,870
	COMMONWEALTH CORPORATION	116,000
	CONNECTICUT DEPARTMENT OF LABOR	1,180,000
	COUNCIL ON COMPETITIVENESS	99,999
	CT DEPARTMENT OF LABOR	1,765,851
	DC DEPARTMENT OF EMPLOYMENT SERVICES	1,000,000
	EMPLOYMENT SECURITY DEPARTMENT	1,000,000
	FLORIDA AGENCY FOR WORKFORCE INNOVATION	9,521,196
	GEORGIA DEPARTMENT OF LABOR	2,513,713
	GOVERNORS OFFICE OF PLANNING AND BUDGET	4,593,276
	HI DEPT OF LABOR & INDUSTRIAL RELATIONS	569,230
	IDAHO DEPARTMENT OF LABOR	1,582,598
	IOWA WORKFORCE DEVELOPMENT	2,183,321
	KANSAS DEPARTMENT OF COMMERCE	17,080,000
	LA DEPARTMENT OF LABOR	17,050,000
	LORAIN COUNTY WORKFORCE INVESTMENT BOARD	249,810
	LOUISIANA DEPARTMENT OF LABOR	300,000
	MA DEPARTMENT OF WORKFORCE DEVELOPMENT	3,184,002
	MAINE DEPARTMENT OF LABOR	2,105,972
	MD DEPARTMENT OF LABOR, LICENSING AND REGULATION	4,000,000
	MICHIGAN DEPARTMENT OF LABOR & ECONOMIC GROWTH	1,616,000
	MINNESOTA DEPARTMENT OF EMPLOYMENT AND ECONOMIC DEVELOPMENT	9,191,000
	MISSISSIPPI DEPARTMENT OF EMPLOYMENT SECURITY	98,366
	MONTANA DEPARTMENT OF LABOR AND INDUSTRY	982,998
	MS DEPARTMENT OF EMPLOYMENT SECURITY	33,117,723
	MUSCOGEE CREEK NATION	3,830,820
	N.H. DEPARTMENT OF LABOR	27,500
	NATIONAL BUSINESS INFORMATION CLEARINGHOUSE	3,338,227
	NC DEPARTMENT OF COMMERCE	1,500,000
	NEW HAMPSHIRE DEPARTMENT OF LABOR	434,946
	NEW JERSEY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT	803,164

US Department of Labor FY 2007 Noncompetitive Grants		
Agency	Grantee	Total
	NEW YORK DEPARTMENT OF LABOR	1,246,750
	NEW YORK STATE (NYS) WORKERS COMPENSATION BOARD	500,000
	NORTH CAROLINA DEPARTMENT OF COMMERCE	11,953,639
	OHIO DEPARTMENT OF JOB AND FAMILY SERVICES	6,316,000
	OREGON DEPARTMENT OF COMMUNITY COLLEGES & WORKFORCE DEVELOPMENT	2,239,959
	PA DEPARTMENT OF LABOR AND INDUSTRY	650,000
	PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY	1,200,000
	PUERTO RICO DEPARTMENT OF LABOR AND HUMAN RESOURCES	529,802
	RI DEPARTMENT OF LABOR AND TRAINING	685,497
	RICHLAND COUNTY JOB AND FAMILY SERVICES	250,000
	SOUTH DAKOTA DEPARTMENT OF LABOR	1,241,995
	SOUTHERN ILLINOIS WORKFORCE INVESTMENT BOARD	250,000
	STATE OF ALASKA	7,500,000
	STATE OF DELAWARE	55,000
	STATE OF GEORGIA - DOL	1,500,000
	STATE OF IDAHO	1,071,822
	STATE OF KANSAS	1,073,000
	STATE OF MAINE - DEPARTMENT OF LABOR	750,000
	STATE OF NORTH CAROLINA	1,184,361
	STATE OF OKLAHOMA	2,616,000
	STATE OF RHODE ISLAND	116,000
	STATE OF UTAH	452,362
	TEXAS WORKFORCE COMMISSION	6,537,413
	UTAH DEPARTMENT OF WORKFORCE SERVICES	115,511
	VA EMPLOYMENT COMMISSION	5,000,000
	WASHINGTON STATE EMPLOYMENT SECURITY DEPARTMENT	4,813,618
	WESTERN GOVERNORS UNIVERSITY	3,000,000
	WI DEPARTMENT OF WORKFORCE DEVELOPMENT	876,452
	MISSOURI DEPARTMENT OF ECONOMIC DEVELOPMENT DIVISION OF WORKFORCE DEVELOPMENT	1,035,373
ETA Total		207,756,674
ILAB	INTL LABOR ORGANIZATION (ILO)	11,400,000
ILAB Total		11,400,000
OSHA	ALABAMA DEPARTMENT OF LABOR	50,370
	ALABAMA UNIV OF, COLLEGE OF CONTINUING STUDIE	1,031,000
	ALASKA DEPT OF LABOR	2,007,160
	ARIZONA INDUSTRIAL COMMISSION	2,477,122
	ARKANSAS DEPT OF LABOR	995,988
	BISMARCK STATE COLLEGE	289,000
	BOISE STATE UNIV DEPT OF COMMUNITY AND ENVIR	437,191

US Department of Labor FY 2007 Noncompetitive Grants		
Agency	Grantee	Total
	CALIFORNIA DEPT OF INDUSTRIAL RELATIONS	28,360,924
	COLORADO STATE UNIV DEPT OF ENVIRONMENTAL HE	959,656
	COMMONWEALTH OR THE NORTHERN MARIAN ISLAND	195,285
	CONNECTICUT DEPT OF LABOR - OSH	1,682,993
	DELAWARE DEPT OF LABOR	459,924
	DISTRICT OF COLUMBIA DEPT OF EMPLOYMENT SERVI	431,675
	GEORGIA DEPARTMENT OF LABOR	55,752
	GEORGIA TECH RESEARCH CORPORATION	1,236,553
	GUAM DEPT OF LABOR	269,985
	HAWAII DEPT OF LABOR AND INDUSTRIAL RELATIONS	2,152,150
	ILLINOIS DEPT OF COMMERCE & COMMUNITY AFFAIRS	1,611,326
	INDIANA DEPT OF LABOR	2,877,619
	INDIANA UNIVERSITY OF PENNSYLVANIA SAFETY SCI	1,588,445
	IOWA DIVISION OF LABOR	676,810
	IOWA, STATE OF	1,608,900
	KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT	88,389
	KANSAS DEPT OF HUMAN RESOURCES	583,000
	KENTUCKY LABOR CABINET OCCUPATIONAL SAFETY	3,328,215
	LOUISIANA DEPARTMENT OF LABOR	21,896
	LOUISIANA DEPT OF EMPLOYMENT & TRAINING, OSHA	669,194
	MAINE DEPT OF LABOR, BUREAU OF LABOR STANDAR	412,329
	MARYLAND DIV OF LABOR AND INDUSTRY	4,489,572
	MASSACHUSETTS DEPT OF LABOR & INDUSTRIES	1,462,533
	MICHIGAN DEPT OF LABOR	1,690,498
	MICHIGAN DEPT OF PUB. HLTH AND MI DEPT OF SAF	9,893,100
	MINNESOTA DEPT OF LABOR AND INDUSTRY	5,005,725
	MISSISSIPPI DEPARTMENT OF HEALTH	19,119
	MISSISSIPPI STATE UNIVERSITY	562,600
	MISSOURI DEPT OF LABOR AND INDUSTRIAL RELATIO	922,366
	MONTANA DEPT OF LABOR & INDUSTRY, BUREAU OF S	424,000
	NEBRASKA DEPT OF LABOR SAFETY DIVISION	551,000
	NEVADA DEPARTMENT OF INDUSTRIAL RELATIONS	1,725,150
	NEW HAMPSHIRE DEPARTMENT OF ENVIRONMNETAL SVC	424,000
	NEW JERSEY DEPARTMENT OF LABOR	1,895,800
	NEW JERSEY DIVISION OF WORKPLACE STANDARDS	1,813,499
	NEW MEXICO HEALTH AND ENVIRONMENT DEPT OF ENV	1,317,147
	NEW YORK DEPT OF LABOR (OSH) PROGRAM	6,724,000
	NORTH CAROLINA DEPARTMENT OF LABOR	5,749,608
	OHIO BUREAU OF WORKERS' COMP	1,421,617
	OHIO DEPT OF INDUSTRIAL RELATIONS	0
	OKLAHOMA DEPT OF LABOR OSHA DIVISION	1,198,653

US Department of Labor FY 2007 Noncompetitive Grants		
Agency	Grantee	Total
	OREGON (OSH) DIVISION	326,000
	OREGON, STATE OF	5,105,700
	PUERTO RICO DEPT OF LABOR AND HUMAN RESOURCES	2,438,800
	RHODE ISLAND DIV. OF OCC. & RADIOLOGICAL HEAL	448,000
	SOUTH CAROLINA DEPT OF LABOR, EDU, TRNING, & C	760,000
	SOUTH CAROLINA DEPT. OF LABOR OSH PROGRAM	1,762,950
	SOUTH DAKOTA STATE UNIV ENGINEERING EXTENSION	415,000
	ST. OF NORTH CAROLINA, DEPT OF LABOR	811,000
	TENNESSEE DEPT OF LABOR -OSH	4,227,829
	TEXAS DEPARTMENT OF INSURANCE	2,690,219
	UNIV OF WI STATE LABORATORY OF HYGIENE	3,837,569
	UNIVERSITY OF ALABAMA	155,494
	UNIVERSITY OF THE VIRGIN ISLANDS	247,409
	UTAH LABOR COMMISSION	10,626
	UTAH OCCUPATIONAL SAFETY & HEALTH DIV.	464,000
	UTAH STATE INDUSTRIAL COMMISSION	1,300,200
	VERMONT DEPT OF LABOR & INDUSTRY	398,750
	VERMONT DEPT OF LABOR AND INDUSTRY	725,800
	VIRGIN ISLANDS DEPT OF LABOR	183,072
	VIRGINIA DEPT OF LABOR AND INDUSTRY	3,319,800
	VIRGINIA DEPT OF LABOR INDUSTRY	1,001,346
	WASHINGTON DEPT OF LABOR AND INDUSTRIES	6,901,600
	WEST VIRGINIA DIV OF LABOR	474,836
	WISCONSIN DEPARTMENT OF INDUSTRY, LABOR, AND	57,293
	WYOMING DEPT OF EMPLOYMENT DIV OF OCC. H & S	942,000
	OSHA Total	142,854,131
VETS	QUAD AREA COMMUNITY ACTION AGENCY, INC.	62,500
	JOINT EFFORTS, INC	62,500
	VIETNAM VETERANS OF SAN DIEGO	50,000
	VOLUNTEERS OF AMERICA OF LOS ANGELES	62,500
	VETERANS BENEFITS CLEARING HOUSE	50,000
	VOLUNTEERS OF AMERICA OF KY, INC.	62,500
	NAT'L ASSOC. OF SYSTEM ADMIN EDU CORP. (NASA)	7,100
	VETERANS MEMORIAL CENTER, INC.	5,000
	AMERICAN LEGION POST # 143-DBA- N ID STND DWN	5,000
	HEART OF AMERICA STAND DOWN FOUNDATION	10,000
	VENTURA COUNTY STAND DOWN	10,000
	WEST MICHIGAN VETERANS ASSISTANCE PROGRAM	6,000
	CITY OF NORFOLK, VIRGINIA	7,000

US Department of Labor FY 2007 Noncompetitive Grants		
Agency	Grantee	Total
	CHICAGO VETERANS ECONOMIC DEVELOPMENT COUNCIL	7,000
	FAIRBANKS STAND DOWN, INC.	7,000
	PHILADELPHIA STAND DOWN, INC.	10,000
	ASTORIA-WARRENTON CHAMBER OF COMMERCE	7,000
	TREASURE STATE VETERANS ASSISTANCE ORGANIZATION, INC.	5,000
	WORK2FUTURE, SAN JOSE	10,000
	VETERANS MEMORIAL CENTER, INC.	5,000
	WALL STREET MISSION DBA GOODWILL INDUSTRIES	6,715
	AMERICAN LEGION MEMORIAL POST 002	7,000
	SOUTHERN OREGON STAND DOWN	10,000
	STAND DOWN OF SOUTH JERSEY, INC.	7,000
	AMERICAN VETERANS	7,000
	VETERAN COMMUNITY PROGRAMS, INC.	7,000
	THE SERVANT CENTER, INC.	7,000
	OPERATION STAND DOWN RHODE ISLAND	10,000
	THE AMERICAN LEGION, DEPARTMENT OF WISCONSIN	7,000
	BOISE HOMELESS STANDDOWN/IDAHO DIV OF VETS SRVCS.	5,000
	NORTH BAY OPERATION HAND UP EVENT (FAIRFIELD)	10,000
	VOICES FOR VETERANS	7,000
	BIG BEND JOBS&EDUCATIONAL COUNCIL, INC(WKFRCEPLS)	7,000
	NAT'L ASSOC. OF SYSTEM ADMIN EDU CORP. (NASA)	10,000
	THE VETERANS OF KERN COUNTY, INC.	10,000
	EL PASO COUNTY HOMELESS VETERAN'S COALITION	7,000
	EL PASO COALITION FOR THE HOMELESS	5,000
	GOODWILL INDUSTRIES, INC.--EASTER SEALS	6,527
	FLORIDA CROWN WORKFORCE BOARD, INC.	5,000
	CHARLOTTE COUNTY HOMELESS COALITION, INC.	3,800
	UTAH DIVISION OF VETERANS AFFAIRS	7,000
	AMERICAN LEGION, DEPARTMENT OF MAINE	7,000
	COMMUNITY COALITION ON HOMELESS CORPORATION(CCH)	7,000
	NEW MEXICO DEPT. OF WORKFORCE SOLUTIONS	10,000
	THURSTON COUNTY--PACIFIC MOUNTAIN WKFR CONSORT.	9,995
	CHEYENNE-ARAPAHO TRIBES OF OKLAHOMA	7,000
	HOMELESS VETERANS SERVICES OF DALLAS, INC	5,000
	EASTERN NEW YORK HOMELESS VETERANS COALITION	7,000
	EMPLOYMENT SECURITY, NH DEPARTMENT OF	6,993

US Department of Labor FY 2007 Noncompetitive Grants		
Agency	Grantee	Total
	ALACHUA COUNTY	7,000
	LEE COUNTY	7,000
	NASSAU COUNTY VETERANS SERVICE AGENCIES	5,000
	CENTRAL LOUISIANA COALITION FOR THE HOMELESS	7,000
VETS Total		689,130
Grand Total		362,699,935

WIA ADULT CARRYOVER BALANCE FOR PY 2007 BY STATE

Mr. Obey: The Administration's request for the Adult Training Program is only \$712 million, a \$150 million cut below the FY 2008 level. Adding insult to injury, you request no adult training funds at all for the first quarter of program operations, from July 1, 2009 through September 30, 2009—meaning that the \$712 million would not become available until October 1, 2009. Officials at the Employment and Training Administration have indicated to State and local workforce agencies that they should plan to use carry-over fund to get them through the first quarter.

Can you please provide for the record, the total amount, and amount by State, of carry-over in the adult funding stream? The amounts should indicate the post-rescission balances, since your budget was prepared knowing that a rescission in these funds had been adopted.

Ms. Chao: The requested information pertaining to the total amount and amount by State of carryover in the WIA Adult funding stream for PY 2007 is contained in the table below. Please note that the summaries by WIA program are estimates due to the fact that a portion of the data collected was limited to totals that combined the WIA Adult funding stream with other programs.

U. S. Department of Labor
Employment and Training Administration
Carryover balance for PY 2007 as of 6/30/07 Reports (as of 01/15/08)
WIA Adult Activities Program - Carry Out to PY 2007

State	Pre- rescission Unexpended Carry-Out to PY 2007 ^{2/}	Full Adult 1% Rescission to FY 2007 Advance	Adult Share of \$250 Mil Rescission ^{3/}	Post-rescission Unexpended Carry-Out to PY 2007
Total	\$327,085,490	(\$7,102,201)	(\$49,158,012)	\$270,825,277
Alabama	3,508,557	(100,687)	(404,835)	3,003,035
Alaska	998,781	(23,908)	(116,080)	858,793
Arizona ^{1/}	3,477,481	(114,288)	(399,528)	2,963,665
Arkansas	5,075,956	(67,354)	(1,604,440)	3,404,162
California	31,982,228	(1,008,114)	(3,679,543)	27,294,571
Colorado	8,883,942	(87,077)	(2,769,828)	6,027,037
Connecticut	1,738,640	(53,884)	(200,139)	1,484,617
Delaware	902,369	(17,756)	(105,087)	779,526
District of Col	3,012,025	(27,853)	(1,386,898)	1,597,274
Florida	22,657,140	(265,657)	(2,844,092)	19,547,391
Georgia	8,834,127	(133,079)	(2,179,918)	6,521,130
Hawaii	752,293	(24,097)	(86,505)	641,691
Idaho	552,711	(20,184)	(63,261)	469,266
Illinois	14,845,743	(349,173)	(1,722,108)	12,774,462
Indiana	10,810,917	(134,466)	(3,559,513)	7,116,938
Iowa	1,431,520	(30,678)	(166,412)	1,234,430
Kansas	4,369,309	(53,316)	(933,058)	3,382,935
Kentucky	5,671,600	(100,771)	(661,782)	4,909,047
Louisiana	7,475,685	(118,886)	(873,945)	6,482,854
Maine	658,882	(22,115)	(75,644)	561,123
Maryland	4,124,989	(73,495)	(635,188)	3,416,306
Massachusetts	3,913,664	(110,208)	(451,828)	3,351,628
Michigan	12,815,225	(355,869)	(1,480,099)	10,979,257
Minnesota	1,887,403	(66,473)	(216,316)	1,604,614
Mississippi	3,029,909	(102,322)	(347,780)	2,579,807
Missouri	3,069,059	(155,375)	(346,129)	2,567,555
Montana	585,523	(19,752)	(67,210)	498,561

State	Pre-rescission Unexpended Carry-Out to PY 2007 ^{2/}	Full Adult 1% Rescission to FY 2007 Advance	Adult Share of \$250 Mil Rescission ^{3/}	Post-rescission Unexpended Carry-Out to PY 2007
Nebraska	2,057,171	(17,756)	(747,034)	1,292,381
Nevada	1,414,691	(32,079)	(164,246)	1,218,366
New Hampshire	1,031,553	(17,756)	(206,278)	807,519
New Jersey	7,327,592	(161,442)	(851,297)	6,314,853
New Mexico ^{1/}	3,933,642	(51,761)	(461,145)	3,420,736
New York	22,013,451	(508,832)	(2,554,623)	18,949,996
North Carolina	6,548,057	(181,764)	(756,278)	5,610,015
North Dakota	901,038	(17,756)	(157,250)	726,032
Ohio	18,759,257	(339,963)	(2,188,104)	16,231,190
Oklahoma	6,642,762	(69,302)	(3,002,064)	3,571,396
Oregon	4,411,632	(123,072)	(509,456)	3,779,104
Pennsylvania	9,803,555	(283,353)	(1,130,944)	8,389,258
Puerto Rico	9,927,905	(260,734)	(1,148,403)	8,518,768
Rhode Island	938,664	(18,392)	(109,323)	810,949
South Carolina	8,058,952	(140,763)	(940,634)	6,977,555
South Dakota	942,857	(17,756)	(109,897)	815,204
Tennessee	9,207,025	(156,724)	(1,370,462)	7,679,839
Texas	27,812,702	(617,815)	(3,230,593)	23,964,294
Utah	2,257,470	(35,479)	(287,609)	1,934,382
Vermont	743,411	(17,756)	(86,204)	639,451
Virginia	4,149,296	(83,147)	(483,035)	3,583,114
Washington	7,542,995	(164,326)	(876,543)	6,502,126
West Virginia	1,070,913	(46,728)	(121,667)	902,518
Wisconsin	1,892,876	(83,152)	(214,985)	1,594,739
Wyoming	630,345	(17,756)	(72,772)	539,817

^{1/} Includes data for Navajo Nation

^{2/} The Unexpended Carry-out Balances do not include information from outlying areas

^{3/} The \$250 million rescission could actually be applied to PY 2005, PY 2006 and PY 2007, but we are showing net estimates here assuming it was all taken from PY 2005 and PY 2006.

WORKFORCE INVESTMENT ACT CARRYOVER FUNDS

Mr. Obey: The Administration pushed to rescind \$335 million from the Workforce Investment Act funds. While we mitigated that cut, the Labor Department argued that the workforce investment system should significantly reduce carry over funds and increase current year training expenditures. That seems inconsistent with telling States to plan on carryover funds in the adult funding stream to get through the first quarter. Should local officials be spending funds on services, or building a cushion of funds out of concern that the Administration will not provide what is needed – which is it?

Ms. Chao: We do not believe that reducing carryover funds and increasing training expenditures are inconsistent with informing states that they should plan to use carryover funds for the adult funding stream in the first quarter of the program year. We recognize that some amount of carryover funds may be necessary, but the amount that has been carried over in recent years is excessive and would be better spent on training and employment services. If each state adheres to the limitation that we have included in our WIA reauthorization proposal of allowing no more than 30 percent of available funds unexpended at the end of any program year to be carried over to the next year, there should be sufficient funds for both increased training and to operate the adult program in the first quarter of the program year.

PROGRAM YEAR 2004 LAPSED WIA FUNDS BY STATE

Mr. Obey: Pages 456-460 of Part 7 of the Hearings on the FY 2008 President's Request provide information on the amount and the percentage of lapsed WIA funds for PY 1999-2003. Please provide an additional chart showing the PY 2004 funds by State that lapsed as of 6/30/07.

Ms. Chao: The requested information is provided in the table below. Please note that the data reflects transfers that occurred between programs after the original allotments were made as authorized under WIA.

Funds Lapsed After 3 Year Expenditure Period
WIA Youth, Adults, and Dislocated Workers Formula Programs
Program Year 2004 Funds Lapsed at End of PY 2006 (per 6/30/07 Report)

State	Amount				% of Total Program Year 2004 Funds			
	Adults	Youth	Dislocated Workers	Total	Adults	Youth	Dislocated Workers	Total
Total	\$527,276	\$300,415	\$614,255	\$1,441,946	0.1%	0.0%	0.1%	0.0%
Alabama	-	-	-	-	0.0	0.0	0.0	0.0
Alaska	27,986	97,952	93,245	219,183	1.0	3.2	2.3	2.2
Arizona**	-	-	-	-	0.0	0.0	0.0	0.0
Arkansas	-	-	-	-	0.0	0.0	0.0	0.0
California	-	1,421	4,119	5,540	0.0	0.0	0.0	0.0
Colorado	-	-	-	-	0.0	0.0	0.0	0.0
Connecticut	257	-	-	257	0.0	0.0	0.0	0.0
Delaware	-	-	-	-	0.0	0.0	0.0	0.0
District of Col	-	-	-	-	0.0	0.0	0.0	0.0
Florida	-	1	-	1	0.0	0.0	0.0	0.0
Georgia	-	-	-	-	0.0	0.0	0.0	0.0
Hawaii	-	-	-	-	0.0	0.0	0.0	0.0
Idaho	-	-	-	-	0.0	0.0	0.0	0.0
Illinois	-	-	-	-	0.0	0.0	0.0	0.0
Indiana	-	-	-	-	0.0	0.0	0.0	0.0
Iowa	916	-	14	930	0.0	0.0	0.0	0.0
Kansas	-	-	-	-	0.0	0.0	0.0	0.0
Kentucky	452,015	160,812	440,306	1,053,133	3.0	1.1	3.5	2.5
Louisiana	-	-	-	-	0.0	0.0	0.0	0.0
Maine	-	-	-	-	0.0	0.0	0.0	0.0
Maryland	-	-	-	-	0.0	0.0	0.0	0.0
Massachusetts	-	-	-	-	0.0	0.0	0.0	0.0
Michigan	-	-	-	-	0.0	0.0	0.0	0.0

State	Amount				% of Total Program Year 2004 Funds			
	Adults	Youth	Dislocated Workers	Total	Adults	Youth	Dislocated Workers	Total
Minnesota	-	-	-	-	0.0	0.0	0.0	0.0
Mississippi	-	20	-	20	0.0	0.0	0.0	0.0
Missouri	-	-	-	-	0.0	0.0	0.0	0.0
Montana	-	-	-	-	0.0	0.0	0.0	0.0
Nebraska	-	-	-	-	0.0	0.0	0.0	0.0
Nevada	32,499	-	8,059	40,558	0.5	0.0	0.2	0.2
New Hampshire	-	-	-	-	0.0	0.0	0.0	0.0
New Jersey	-	-	-	-	0.0	0.0	0.0	0.0
New Mexico**	-	-	-	-	0.0	0.0	0.0	0.0
New York	-	1	-	1	0.0	0.0	0.0	0.0
North Carolina	-	-	-	-	0.0	0.0	0.0	0.0
North Dakota	-	-	-	-	0.0	0.0	0.0	0.0
Ohio	-	-	-	-	0.0	0.0	0.0	0.0
Oklahoma	13,602	12,247	68,512	94,361	0.2	0.1	0.8	0.4
Oregon	-	-	-	-	0.0	0.0	0.0	0.0
Pennsylvania	-	-	-	-	0.0	0.0	0.0	0.0
Puerto Rico	-	27,961	-	27,961	0.0	0.1	0.0	0.0
Rhode Island	-	-	-	-	0.0	0.0	0.0	0.0
South Carolina	-	-	-	-	0.0	0.0	0.0	0.0
South Dakota	-	-	-	-	0.0	0.0	0.0	0.0
Tennessee	-	-	-	-	0.0	0.0	0.0	0.0
Texas	-	-	-	-	0.0	0.0	0.0	0.0
Utah	-	-	-	-	0.0	0.0	0.0	0.0
Vermont	-	-	-	-	0.0	0.0	0.0	0.0
Virginia	-	-	-	-	0.0	0.0	0.0	0.0
Washington	1	-	-	1	0.0	0.0	0.0	0.0
West Virginia	-	-	-	-	0.0	0.0	0.0	0.0

State	Amount				% of Total Program Year 2004 Funds			
	Adults	Youth	Dislocated Workers	Total	Adults	Youth	Dislocated Workers	Total
Wisconsin	-	-	-	-	0.0	0.0	0.0	0.0
Wyoming	-	-	-	-	0.0	0.0	0.0	0.0

** Includes funds for the Navajo Nation issued in a separate grant.

CHARACTERISTICS OF WIA PROGRAM PARTICIPANTS

Mr. Obey: Please update the table on pages 447-448 of Part 7 of the Hearings on the FY 2008 President's Request. This table provides valuable information on the characteristics of WIA program participants and information from PY 2006 should now be available.

Ms. Chao: Once a year, ETA receives participant data for individuals who have exited the WIA Adult, Dislocated Worker and Youth Programs. The table shared below provides the characteristics of those participants who exited in Program Year (PY) 2006. The reported percentages are based on validated information submitted by states and are derived from the WIA Standardized Record Data (WIASRD) files.

Characteristics of Program Participants April 2006-March 2007	Adult	Dislocated Worker	Older Youth	Younger Youth
TOTAL NUMBER OF EXITERS	510,034	259,564	28,059	88,539
Gender				
Male	51.3%	46.2%	38.9%	46.2%
Female	48.7%	53.8%	61.1%	53.8%
Age Category				
14 to 18	N/A	N/A	N/A	100%
18 to 21	9.8%	N/A	100%	N/A
Under 22	N/A	5.0%	100%	100%
22 to 44	62.1%	55.8%	0%	0%
45 to 54	18.6%	25.9%	0%	0%
55 and over	9.6%	13.2%	0%	0%
Individual with a Disability	4.9%	3.9%	10.2%	16.7%
Race/Ethnicity				
Hispanic	14.5%	11.5%	22.9%	29.5%
Not Hispanic				

Characteristics of Program Participants April 2006-March 2007	Adult	Dislocated Worker	Older Youth	Younger Youth
American Indian or Alaska Native (only)	1.3%	0.7%	1.4%	1.5%
Asian (only)	2.4%	2.8%	1.7%	2.4%
Black or African American (only)	29.9%	33.1%	38.2%	34.6%
Hawaiian Native or other Pacific Islander (only)	0.2%	0.2%	0.4%	0.4%
White (only)	50.4%	50.5%	34.1%	28.8%
More than one race	1.3%	1.2%	1.4%	1.3%
Veteran	7.9%	8.4%	0.4%	
Disabled Veteran	1.0%	1.1%	N/A	N/A
Campaign Veteran	1.9%	2.9%	N/A	N/A
Recently Separated Veteran	1.3%	1.2%	N/A	N/A
Employed at Registration	18.3%	8.4%	16.7%	6.6%
Displaced Homemaker	N/A	1.7%	N/A	N/A
Registered Before Layoff	N/A	7.4%	N/A	N/A
Registered within 8 Weeks of Layoff	N/A	31.8%	N/A	N/A
Average Preprogram Quarterly Earnings (among those with positive earnings)	\$5,923	\$7,366	\$1,756	N/A
	Of Those Who Received Intensive or Training Services		All Youth Exiters	
Limited English-Language Proficiency	4.9%	5.0%	3.6%	9.6%
Single Parent	19.8%	13.5%	23%	N/A
UI Claimant	16.1%	58.2%	3.5%	4.6%
UI Claimant Referred by Worker Profiling Reemployment Services	3.3%	19.9%	0.7%	1.6%
UI Exhaustee	3.9%	8.5%	0.9%	0.3%
Low Income	53.7%	N/A	95.0%	84.3%
Public Assistance Recipient	14.5%	N/A	23.6%	22.2%
TANF	5.6%	N/A	10.8%	8.4%
Other Public Assistance Recipient	10.6%	N/A	15.6%	15.9%
Highest Grade Completed (avg)	12.4%	12.6%	11.3%	

Characteristics of Program Participants April 2006-March 2007	Adult	Dislocated Worker	Older Youth	Younger Youth
8th or Less	2.9%	3.2%	3.5%	20.7%
Some High School	13.9%	10.7%	41.6%	70.5%
High School Graduate	44.0%	43.1%	42.3%	5.9%
High School Equivalency	7.9%	5.6%	5.5%	1.0%
Some Postsecondary	22.7%	25.1%	6.9%	0.4%
College Graduate (4-year)	8.6%	12.4%	0.2%	N/A
Education Status at Registration				
Attending School	N/A	N/A	15.8%	76.1%
High School or Below	N/A	N/A	7.0%	72.3%
Alternative School	N/A	N/A	1.0%	1.8%
Postsecondary	N/A	N/A	7.9%	1.5%
Not Attending School	N/A	N/A	84.2%	23.8%
High School Dropout	N/A	N/A	37.2%	18.0%
High School Graduate (or Equivalent)	N/A	N/A	47.0%	5.8%
Basic Literacy Skills Deficiency	N/A	N/A	54.2%	63.7%
Homeless Individual and/or Runaway Youth	N/A	N/A	4.1%	2.0%
Offender	N/A	N/A	11.4%	8.2%
Pregnant or Parenting Youth	N/A	N/A	31.2%	6.7%
Youth who Needs Additional Assistance	N/A	N/A	56.1%	56.4%

JOB CORPS BACKLOG OF UNFUNDED BUILDING MAINTENANCE AND REPAIR NEEDS

Mr. Obey: Included in the President's fiscal year 2009 proposed budget is \$110 million for Job Corps' construction account, which represents a \$3 million reduction from the fiscal year 2008 level. About \$59 million of this funding is set-aside for the construction of two new Job Corps centers in Iowa and New Hampshire. Job Corps has over 2,200 buildings having a combined total of more than 24 million square feet. The average age of these buildings is 42 years. The current replacement value was more than \$4.1 billion in January 2005.

Based on recent architectural and engineering reviews that have been conducted at all Job Corps centers, please provide the cost of the backlog of immediate unfunded building maintenance and repair needs, and the cost of the backlog of needs for replacement or major alteration of old buildings (buildings that are becoming unserviceable as measured by industry standards)?

Ms. Chao: Job Corps funds maintenance at all centers through the center operating contracts (and transfers to USDA and DOI for agency operated centers). Each center has an Operations Plan to address their maintenance needs and center operators receive an annual operations and maintenance budget to perform routine maintenance and repairs at the center.

Those repairs that are identified as being beyond the cost of the normal maintenance program or the expertise of the maintenance personnel are included in the center's inventory of needs, established during facility surveys or identified by the center maintenance personnel. These deficiency repairs are carried out using existing Job Corps construction funds. Where the deficiencies on a building are numerous or major, a rehabilitation project or replacement of a building will be recommended. All defects that would impact the safety and/or health of students or staff are funded immediately, as are any deficiencies that would negatively impact the environment. The estimated cost of deficiencies (excluding health/safety/environmental) at all centers is approximately \$145 million and the estimated cost of buildings needing replacement or major renovations is \$638.6 million. The long term plan is to reduce repairs substantially at current funding levels by focusing more resources on addressing building deficiencies, and less on new construction.

Mr. Obey: How will the Department address the backlog of repairs and renovations and new building construction on existing facilities with only \$50 million remaining after the set-aside for the new centers?

Ms. Chao: Job Corps has a system in place to identify, with the input of center operators and program staff, those repair and renovation priorities that should receive funding each program year. In accordance with the Department's Asset Management Plan, all of the deficiencies are rated to determine the impact on the facility or program and the cost/benefit of repair or replacement is analyzed. Using this process, the majority of the \$50 million will be used for repairs, renovations and building construction on existing facilities that are determined to be of the highest priority. Job Corps normally budgets \$20 million - \$30 million each year to repair the most critical deficiencies, which are those that impact the safety or health of students or staff or which would negatively impact the environment, and plans to do so with the Job Corps construction account funding received for such purposes in FY 2009. There is also normally a budget of approximately \$60M million each year for building replacement or major renovations. The funding normally used for building replacement and major renovations will be diverted in FY 2009 to construct two new centers in New Hampshire and Iowa.

OLMS RESTITUTION ORDERS

Mr. Obey: Your testimony indicates that the Office of Labor Management Standards (OLMS) achieved restitution of \$32 million in 2007.

Does the \$32 million include restitution orders for cases worked with other law enforcement agencies such as the FBI, the Employee Benefits Security Administration (EBSA), or the Department's Inspector General's office?

Ms. Chao: The \$32 million figure cited in the testimony was inaccurate because it overstated the amount of restitution ordered in OLMS cases. The error occurred because the OLMS Buffalo District Office entered an incorrect figure into OLMS' electronic case recordkeeping system, the Case Data System (CDS). This error was recognized on March 26, 2008. When this error is removed from CDS, the amount of funds subject to restitution orders in 2007 equaled \$14,922,344. OLMS has undertaken to audit each of its criminal cases closed from October 1, 2000 to the present to ensure accuracy.

The restitution orders include cases that the Department of Labor's Office of Labor-Management Standards (OLMS) worked alone and those that OLMS worked jointly with one or more other law enforcement agencies.

Mr. Obey: For the record please provide a breakdown of the \$32 million in court-ordered restitution – by individual OLMS case – and include information on what role, if any, other agencies had in the case.

Ms. Chao: As mentioned above, the \$32 million figure cited in the testimony was inaccurate. The table provided below lists individual OLMS convictions from October 1, 2006 to September 30, 2007, the fiscal year noted in my testimony.

The report lists, among other entries, the OLMS case number, the labor organization, the subject of the investigation, the date of conviction, and the amount of restitution ordered. The total number of cases and the total amount of restitution ordered appear on the bottom of the final page.

The report also contains an entry titled "Joint Inv" and, in this field OLMS notes whether the case was investigated jointly with other law enforcement agencies. In OLMS' Case Data System, the investigator reviews a list of law enforcement agencies and enters a check to record the law enforcement agency, if any, involved in the case. These entries are then reflected on reports, like the one attached.

In the table provided below, the cases identified as "OLMS alone" were handled without the participation of any other law enforcement agency. The document also shows entries for "FBI," "OIG," "Other Fed," "local" and "Multiple." The

“FBI” entry refers to the Federal Bureau of Investigation. The “OIG” entry refers to the Office of the Inspector General. (It is used to denote any OIG office, whether the Department of Labor OIG or otherwise.) The “Other Fed” refers to any other federal law enforcement agency for which there is no corresponding entry in OLMS Case Data System. The term “Local” refers to any state or local law enforcement agency. The “Multiple” entry is used when more than one other law enforcement agency works with OLMS on a case. When the “Multiple” entry is used, no record is made of the specific agencies involved in the case.

OLMS’ recordkeeping systems, including the Case Data System, do not contain information on the role of each agency in jointly investigated cases. The DOL OIG is the lead agency in cases in which there is organized crime and labor racketeering.

DATE	DO	PR	NO.	UNION	LOCATION	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y or N	FINE	RESTITUTION	504 BAR		INVESTIGATOR
													YEARS	MONTHS	
CASE NO.	DO	PR	NO.	UNION	CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y or N	FINE	RESTITUTION	CONF	SUPERV	INVESTIGATOR
110-18774-08				NATIONAL EDUCATION ASSN IND SA	AUGUSTA	ME	CROSER, Other Employees	OLMS Only	05/07/2007	N	\$0	\$45,503	13	6	35
				INDICTMENT CITATIONS			29 U.S.C. 531(c)								
				JUDICIAL DISTRICT			Mare Name								
110-18818-08				STATE COUNTY & MUNI EMP'LS AFL-CIO LU 2511	BOSTON	MA	ADAMS, Ex President	OLMS Only	07/10/2007	N	\$80	\$11,160	13	0	13
				INDICTMENT CITATIONS			Other Local								
				JUDICIAL DISTRICT			Local Prosecutor Massachusetts								
110-18818-08				NORTHEAST EMERGENCY SERVICES UNION	WALLINGFORD	CT	KONGSPORE, Other Officer	OLMS Only	04/02/2007	N	\$0	\$81,605	13	5	36
				INDICTMENT CITATIONS			29 U.S.C. 501(c)								
				JUDICIAL DISTRICT			Connecticut								
110-18855-08				GOVERNMENT EMP'LS, NAGE	PITTSFIELD	MA	HASKINS, Ex Other Officer	OLMS Only	05/25/2007	N	\$60	\$2,192	13	0	12
				INDICTMENT CITATIONS			Other Local								
				JUDICIAL DISTRICT			Local Prosecutor Massachusetts								
120-08526-08				PLASTERERS & CEMENT MASONS AFL-CIO LU 9	AMHERST	NY	TAKACS, Secretary-Treasurer	OLMS Only	10/17/2006	N	\$1,000	\$0	13	0	0
				INDICTMENT CITATIONS			29 U.S.C. 438(c)								
				JUDICIAL DISTRICT			Western New York								
120-08562-08				COMMUNICATIONS WORKERS AFL-CIO LU 81328	LANCASTER	NY	NAUTE, President	OLMS Only	12/05/2006	N	\$0	\$2,291	0	0	12
				INDICTMENT CITATIONS			Other Federal								
				JUDICIAL DISTRICT			Western New York								
120-08564-08				STAGE & PICTURE OPERATORS AFL-CIO LU 9	SYRACUSE	NY	RUSSELL, Ex Secretary-Treasurer	OLMS Only	05/24/2007	N	\$0	\$54,777	13	6	60
				INDICTMENT CITATIONS			29 U.S.C. 501(c)								
				JUDICIAL DISTRICT			Northern New York								

DATE	CASE NO	PR NO	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y or N	FINE	RESTITUTION	504 BAR YEARS		INVESTIGATOR
												CONFIN	SUPERV	
03/26/2008	120-06582-08		MUSICIANS AFL-CIO LU 12	BUFFALO	NY	JONES, President	OLMS Only	11/29/2006	N	\$0	\$75,410	13	0	24
			INDICTMENT CITATIONS: 29 U.S.C. 501(c) JUDICIAL DISTRICT, Western New York				PROSECUTOR							
	120-08641-08		NURSES ASN, AMERICAN, IND SA	LATHAM	NY	JOHN, Ex Other Employee	Local	05/30/2007	N	\$0	\$1,183,670	13	120	0
			INDICTMENT CITATIONS: Other Local JUDICIAL DISTRICT, Local Prosecutor, New York				PROSECUTOR							
	130-12174-08		ELEVATOR CONSTRUCTORS AFL-CIO LU 1	LONG ISLAND CITY	NY	CAPOZZOLI, Member	FBI	04/18/2007	N	\$200	\$75,216	13	0	36
			INDICTMENT CITATIONS: 29 U.S.C. 186 18 U.S.C. 1341 JUDICIAL DISTRICT, Eastern New York				PROSECUTOR							
	130-12387-08		ENGINEERS, OPERATING, AFL-CIO LU 14	FLUSHING	NY	FREDERICK, Employer	FBI	07/11/2007	N	\$0	\$8,885,000	13	0	60
			INDICTMENT CITATIONS: 29 U.S.C. 186 18 U.S.C. 371 Other Federal Eastern New York JUDICIAL DISTRICT				PROSECUTOR							
	130-12382-08		LETTER CARRIERS, NATL ASN AFL-CIO BR 36	NEW YORK	NY	CLARK, Ex Secretary-Treasurer	OLMS Only	06/22/2007	N	\$100	\$65,085	156	6	36
			INDICTMENT CITATIONS: 29 U.S.C. 501(c) JUDICIAL DISTRICT, Southern New York				PROSECUTOR							
	130-12686-08		GLASS MOLDERS PLASTICS AFL-CIO LU 238 A	MEDIA	PA	CLAYTON, Ex Secretary-Treasurer	OLMS Only	06/27/2007	N	\$0	\$41,126	13	0	6
			INDICTMENT CITATIONS: 29 U.S.C. 501(c) 18 U.S.C. 1510 JUDICIAL DISTRICT, New Jersey				PROSECUTOR							
	140-10279-08		SERVICE EMPLOYEES LU 36	PHILADELPHIA	PA	SWEENEY, Ex Bookkeeper/Office Sec	OLMS Only	06/22/2007	N	\$0	\$5,935	0	0	24
			INDICTMENT CITATIONS: Other Local JUDICIAL DISTRICT, Local Prosecutor, Pennsylvania				PROSECUTOR							

OFFICE OF LABOR-MANAGEMENT STANDARDS
CONVICTIONS
10/01/2006 - 09/30/2007

DATE: 03/26/2006
COS: 37

CASE NO.	PR NO.	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL or N	FINE	RESTITUTION	504 BAR YEARS		INVESTIGATOR
											CONFIN	SUPERV	
140-10342-08		RETAIL WHOLESALE, DC, UFCW LU 1034	PHILADELPHIA	PA	GROOM, Ex President	OLMS Only	08/06/2007	N	\$0	\$13,040	0	0	
		INDICTMENT CITATIONS: JUDICIAL DISTRICT			Other Local Local Prosecutor Pennsylvania								
140-10390-08		BAKERS INDEPENDENT UNION	KING OF PRUSSIA	PA	BALDWIN, Ex President	OLMS Only	04/03/2007	N	\$0	\$8,200	13	0	
		INDICTMENT CITATIONS JUDICIAL DISTRICT			Other Local Local Prosecutor Pennsylvania								
140-10418-08		RETAIL WHOLESALE, DC, UFCW LU 1034	PHILADELPHIA	PA	LEWIS, Ex Secretary-Treasurer	OLMS Only	08/06/2007	N	\$0	\$10,265	0	0	
		INDICTMENT CITATIONS JUDICIAL DISTRICT			Other Local Local Prosecutor Pennsylvania								
140-10452-08		GRAPHIC COMMUNICATIONS, BT LU 735 S	HAZLETON	PA	ORZUT, Secretary-Treasurer	OLMS Only	04/23/2007	N	\$600	\$21,099	13	6	
		INDICTMENT CITATIONS JUDICIAL DISTRICT			29 U.S.C. 433(c) 29 U.S.C. 501(c) Middle Pennsylvania								
140-10479-08		COMMUNICATIONS WORKERS AFL-CIO LU 23	WILKES BARRE	PA	HONALD, Ex Secretary-Treasurer	OLMS Only	03/28/2007	N	\$0	\$4,458	13	3	
		INDICTMENT CITATIONS JUDICIAL DISTRICT			29 U.S.C. 438(c) Middle Pennsylvania								
140-10504-08		MACHINISTS AFL-CIO LU 1070	PALMYRA	PA	MCCLEARN, Ex Secretary-Treasurer	OLMS Only	10/18/2005	N	\$0	\$0	0	0	
		INDICTMENT CITATIONS JUDICIAL DISTRICT			Other Federal Middle Pennsylvania								
140-10546-08		LABORERS LU 332	PHILADELPHIA	PA	WESLEY, Ex Other Employee	OLMS Only	06/15/2007	N	\$0	\$2,379	13	0	
		INDICTMENT CITATIONS JUDICIAL DISTRICT			Other Local Local Prosecutor Pennsylvania								

DATE DO NO.	CASE PR NO.	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y or N	FINE	RESTITUTION	504 BAR YEARS		MONTHS CONFRN	SUPERV	INVESTIGATOR
											YEARS	0			
210-01572-08	DLG 154	MACHINISTS AFL-CIO	CALVERT CITY	KY	HENDRICKS, Ex Bookkeeper/Office Sec	OLMS Only	12/04/2008	N	\$0	\$0	0	0	0	0	
		INDICTMENT CITATIONS:	Other Local												
		JUDICIAL DISTRICT:	Local Prosecutor Kentucky			PROSECUTOR									
210-01587-08	LU 217	ELECTRICAL WORKERS IBEW AFL-CIO	CINCINNATI	OH	GRIFFIE, Employer	OLMS Only	02/15/2007	N	\$0	\$0	0	0	0	12	
		INDICTMENT CITATIONS:	Other Local												
		JUDICIAL DISTRICT:	Southern Ohio			PROSECUTOR									
210-01617-09	LU 183	SHEET METAL WORKERS AFL-CIO	CINCINNATI	OH	LIMING, Ex Business Manager	OLMS Only	01/24/2007	N	\$250	\$2,421	0	0	0	36	
		INDICTMENT CITATIONS:	18 U.S.C. 1344												
		JUDICIAL DISTRICT:	Southern Ohio			PROSECUTOR									
220-15457-08	LU 11	STATE COUNTY & MUNI EMPLS AFL-CIO	WESTERVILLE	OH	WALTERS, Secretary-Treasurer	OLMS Only	06/25/2007	N	\$0	\$22,881	13	6	60		
		INDICTMENT CITATIONS:	29 U.S.C. 435(c), 29 U.S.C. 501(c)												
		JUDICIAL DISTRICT:	Southern Ohio			PROSECUTOR									
220-15481-08	LU 11	STATE COUNTY & MUNI EMPLS AFL-CIO	WESTERVILLE	OH	PETERSON, Other Officer	OLMS Only	12/07/2006	N	\$0	\$6,309	13	0	0	0	
		INDICTMENT CITATIONS:	29 U.S.C. 501(c)												
		JUDICIAL DISTRICT:	Southern Ohio			PROSECUTOR									
220-15484-08	LU 18	ENGINEERS, OPERATING, AFL-CIO	CLEVELAND	OH	SEGURA, Ex Bookkeeper/Office Sec	OLMS Only	12/16/2006	N	\$0	\$5,649	13	0	60		
		INDICTMENT CITATIONS:	29 U.S.C. 501(c)												
		JUDICIAL DISTRICT:	Northern Ohio			PROSECUTOR									
220-15484-08	LU 998	ELECTRICAL WORKERS IBEW AFL-CIO	VERMILION	OH	WARD, Ex Secretary-Treasurer	OLMS Only	10/05/2004	N	\$0	\$24,119	13	6	36		
		INDICTMENT CITATIONS:	29 U.S.C. 435(b), 29 U.S.C. 501(c)												
		JUDICIAL DISTRICT:	Northern Ohio			PROSECUTOR									

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OFFICE OF LABOR-MANAGEMENT STANDARDS CONVICTIONS 10/01/2008 - 09/30/2007														
CASE PR DO NO	DATE	03/26/2008 COS 37	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y or N	FINE	RESTITUTION	504 BAR YEARS	MONTHS CONFIN SUPERV	INVESTIGATOR
240-11928-08			POSTAL MAIL HANDLERS, LUANA LU 305	RICHMOND	VA	NELSON, Ex Other Officer	OLMS Only	11/21/2006	N	\$0	\$5,363	13	4	36
			INDICTMENT CITATIONS JUDICIAL DISTRICT			29 U.S.C. 301(c) Eastern Virginia								
240-11956-08			TEACHERS AFL-CIO LU 5	WASHINGTON	DC	HOLMES, Ex Other Employee	Multiple	10/17/2006	N	\$0	\$855,000	14	12	36
			INDICTMENT CITATIONS JUDICIAL DISTRICT			Other Federal District of Columbia								
240-11967-08			TEACHERS AFL-CIO LU 6	WASHINGTON	DC	MARTIN Other	Multiple	10/13/2006	N	\$0	\$650,000	13	18	36
			INDICTMENT CITATIONS JUDICIAL DISTRICT			18 U.S.C. 2 Other-Federal District of Columbia								
240-11992-08			TEACHERS AFL-CIO LU 6	WASHINGTON	DC	ALDERMAN, Other	Multiple	10/27/2006	N	\$0	\$541,262	13	12	48
			INDICTMENT CITATIONS JUDICIAL DISTRICT			18 U.S.C. 371 District of Columbia								
240-11993-08			SERVICE EMPLOYEES LU 1050	SEVERY	MO	WOMACK, Ex Secretary-Treasurer	OLMS Only	05/25/2007	N	\$0	\$3,326	13	0	0
			INDICTMENT CITATIONS JUDICIAL DISTRICT			Other Local District of Columbia								
240-12016-08			TEACHERS AFL-CIO LU 6	WASHINGTON	DC	KLEIN, Other	Multiple	10/13/2006	N	\$0	\$0	13	9	48
			INDICTMENT CITATIONS JUDICIAL DISTRICT			29 U.S.C. 438(c) 18 U.S.C. 371 18 U.S.C. 1001 District of Columbia								
240-12021-08			TEACHERS AFL-CIO LU 6	WASHINGTON	DC	MARTIN, Other	Multiple	10/23/2006	N	\$0	\$550,000	13	18	48
			INDICTMENT CITATIONS JUDICIAL DISTRICT			18 U.S.C. 371 District of Columbia								
							PROSECUTOR							

OFFICE OF LABOR-MANAGEMENT STANDARDS CONVICTIONS 10/1/2008 - 09/30/2007													
DATE DO NO.	CASE PR NO.	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONV CTN DATE	TRIAL Y or N	FINE	RESTITUTION	504 BAR YEARS		INVESTIGATOR
											CONFIRN	MONTHS SUPERV.	
240-12087-08		CARPENTERS IND LU 1402	RICHMOND	VA	TAYLOR, Other Officer	OLMS Only	05/25/2007	N	\$35,074	\$98,422	14	12	0
		INDICTMENT CITATIONS JUDICIAL DISTRICT	18 U.S.C. 1201 Eastern Virginia			PROSECUTOR							
240-12106-08		COMMUNICATIONS WORKERS AFL-CIO NHQ	WASHINGTON	DC	DORSEY, Ex Other Employee	OLMS Only	08/22/2007	N	\$0	\$0	13	0	38
		INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 571(c) District of Columbia			PROSECUTOR							
240-12123-08		TRANSPORTATION UNION IND LU 1848	HANDOVER	PA	FISHER, Ex Secretary-Treasurer	OLMS Only	07/12/2007	N	\$0	\$45,000	14	12	24
		INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 501(c) Maryland			PROSECUTOR							
240-12256-08		AFL-CIO NHQ	WASHINGTON	DC	BURTON, Other Employee	OLMS Only	07/20/2007	N	\$350	\$7,963	0	0	12
		INDICTMENT CITATIONS JUDICIAL DISTRICT	Other Local Local Prosecutor District of Columbia			PROSECUTOR							
310-22270-08		COMMUNICATIONS WORKERS AFL-CIO LU 84199	HINSDALE	IL	STACKS, Ex Business Manager	OLMS Only	11/08/2006	N	\$0	\$66,405	13	1	5
		INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 501(c) Northern Illinois			PROSECUTOR							
310-22468-08		COMMUNICATIONS WORKERS AFL-CIO LU 14028	PEORIA	IL	SUDUTH, Ex Secretary-Treasurer	OLMS Only	07/27/2007	N	\$0	\$15,908	15	6	36
		INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 438(b) Central Illinois			PROSECUTOR							
310-22500-08		PRINTERS AFL-CIO LU 1154	PEORIA	IL	WEBBER, Ex Secretary-Treasurer	OLMS Only	03/06/2007	N	\$500	\$0	13	0	1
		INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 438(c) Central Illinois			PROSECUTOR							

OFFICE OF LABOR-MANAGEMENT STANDARDS CONVICTIONS 10/01/2006 - 09/30/2007													
DATE DO NO NC	CASE PR NO	UNION	LOCATION		SUBJECT	JOINT INV	CONVICTION DATE	TRIAL or N	FINE	RESTITUTION	504 BAR YEARS		INVESTIGATOR
			CITY	ST							CONFIN	SUPERV	
330-07749-08		COMMUNICATIONS WORKERS AFL-CIO LU 84101	MILWAUKEE	WI	ROBINSON, Ex President	OLMS Only	12/14/2006	N	\$0	\$5,984	13	0	36
		INDICTMENT CITATIONS JUDICIAL DISTRICT: Eastern Wisconsin				PROSECUTOR							
		COMMUNICATIONS WORKERS AFL-CIO LU 84101	MILWAUKEE	WI	CARTER, Ex Secretary-Treasurer	OLMS Only	11/21/2006	N	\$0	\$0	13	0	13
330-07767-08		INDICTMENT CITATIONS JUDICIAL DISTRICT: Eastern Wisconsin				PROSECUTOR							
		HOTEL EMPL, RESTAURANT EMPL AFL-CIO LU 21	ROCHESTER	MN	BRONSON, Ex Other Officer	OLMS Only	02/22/2007	N	\$0	\$29,801	13	6	36
		INDICTMENT CITATIONS JUDICIAL DISTRICT: Minnesota				PROSECUTOR							
340-10491-08		LETTER CARRIERS, NATL ASN AFL-CIO BR 30	KANSAS CITY	MO	COLE, Bookkeeping Office Secy	OLMS Only	03/22/2007	N	\$25	\$4,731	13	6	36
		INDICTMENT CITATIONS JUDICIAL DISTRICT: Western Missouri				PROSECUTOR							
		POSTAL WORKERS, AMERICAN, AFL-CIO LU 238	KANSAS CITY	KS	KENDRICK, Secretary-Treasurer	OLMS Only	08/17/2007	N	\$0	\$26,236	13	6	60
340-10499-08		INDICTMENT CITATIONS JUDICIAL DISTRICT: Kansas				PROSECUTOR							
		POSTAL MAIL HANDLERS, LUWA LU 287	RAYTOWN	MO	JOHNSON, Ex President	OLMS Only	07/19/2007	N	\$1,000	\$4,411	13	0	24
		INDICTMENT CITATIONS JUDICIAL DISTRICT: Western Missouri				PROSECUTOR							
340-10520-08		BOILERMAKERS AFL-CIO LU 148 M	INDEPENDENCE	MO	UPTEGROVE, Ex Secretary-Treasurer	OLMS Only	05/11/2007	N	\$2,000	\$0	13	6	24
		INDICTMENT CITATIONS JUDICIAL DISTRICT: Western Missouri				PROSECUTOR							

DATE	DO	PR	NO	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL or N	FINE	RESTITUTION	504 BAR		INVESTIGATOR
													YEARS	MONTHS	
CASE NO	PR	NO	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL or N	FINE	RESTITUTION	INVESTIGATOR	YEARS	MONTHS	INVESTIGATOR
340-10566-06			BOILERMAKERS AFL-CIO NHQ	KANSAS CITY	KS	WAGNER Other	Multiple	04/09/2007	N	\$0	\$0		0	12	
			INDICTMENT CITATIONS	18 U.S.C. 1001 Other Federal											
			JUDICIAL DISTRICT	Kansas											
340-10511-08			POSTAL WORKERS, AMERICAN AFL-CIO LU 7085	ASHLAND	MO	HLAVACEK, Secretary-Treasurer	CLMS Only	08/07/2007	N	\$0	\$4,783		13	0	36
			INDICTMENT CITATIONS	29 U.S.C. 501(c)											
			JUDICIAL DISTRICT	Western Missouri											
340-10516-06			*TRANSPORTATION COMM UNION AFL-CIO LG 512	COUNCIL BLUFFS	IA	TOWNSEND, Ex Other Officer	CLMS Only	01/05/2007	N	\$0	\$3,627		1	0	12
			INDICTMENT CITATIONS	29 U.S.C. 511(c)											
			JUDICIAL DISTRICT	Eastern Missouri											
340-10655-08			GOVERNMENT EMPLOYEES AFGE AFL-CIO LJ 95	ST LOUIS	MO	LOVE, President	CLMS Only	03/02/2007	Y	\$0	\$58,125		13	18	36
			INDICTMENT CITATIONS	18 U.S.C. 661 18 U.S.C. 1003											
			JUDICIAL DISTRICT	Eastern Missouri											
340-10658-06			GOVERNMENT EMPLOYEES AFGE AFL-CIO LJ 95	ST LOUIS	MO	FRANCE, Secretary-Treasurer	CLMS Only	01/12/2007	N	\$0	\$26,650		13	0	60
			INDICTMENT CITATIONS	18 U.S.C. 661 18 U.S.C. 1001											
			JUDICIAL DISTRICT	Eastern Missouri											
340-10682-08			BOILERMAKERS AFL-CIO LG 8 S	HARRISBURG	IL	KLOPE, Ex Secretary-Treasurer	CLMS Only	08/20/2007	N	\$100	\$0		13	0	36
			INDICTMENT CITATIONS	29 U.S.C. 501(c)											
			JUDICIAL DISTRICT	Southern Illinois											
340-10721-08			ILLINOIS DEPARTMENT OF CORRECTIONS	CLAREMONT	IL	KOHLBAUGH, Ex President	CLMS Only	08/23/2007	N	\$25	\$1,303		13	0	24
			INDICTMENT CITATIONS												
			JUDICIAL DISTRICT	Southern Illinois											

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OFFICE OF LABOR-MANAGEMENT STANDARDS														
CONVICTIONS														
10/11/2006 - 09/30/2007														
DATE DO NO	CASE NO	PR	UNION	LOCATION		ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL or N	FINE	RESTITUTION	504 BAR YEARS	
				CITY	CITY								CONFIN	SUPERV
410-14475-08			LONGSHOREMEN'S ASN AFL-CIO LU 1740	SAN JUAN	PR	PR	RAMALLO DIAZ, Other	FBI	08/14/2007	N	\$250,000	\$325,000	0	36
410-14476-08			INDICTMENT CITATIONS JUDICIAL DISTRICT	18 U.S.C. 371	Other Federal	Other Federal	Other Federal	PROSECUTOR						
420-13233-08			LONGSHOREMEN'S ASN AFL-CIO LU 1740	SAN JUAN	PR	PR	RAMALLO DIOS, Other	FBI	08/14/2007	N	\$250,000	\$325,000	0	3
420-13234-08			INDICTMENT CITATIONS JUDICIAL DISTRICT	18 U.S.C. 371	Other Federal	Other Federal	Other Federal	PROSECUTOR						
420-13253-08			STATE COUNTY & MUNI EMPLOYEES AFL-CIO LU 48	LITTLE ROCK	AR	AR	FISKE Ex Bookkeep Office Sec	OLMS Only	03/22/2007	N	\$100	\$33,725	13	3
420-13280-08			GLASS MOLDERS PLASTICS AFL-CIO LU 2582	HENRYETTA	OK	OK	BROWNFIELD Secretary-Treasurer	OLMS Only	12/27/2006	N	\$0	\$25,601	13	5
420-13280-08			INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 501(c)	Eastern Oklahoma	Eastern Oklahoma	Eastern Oklahoma	PROSECUTOR						
420-13286-08			GOVERNMENT EMPLOYEES AFGE AFL-CIO LU 6127	OKLAHOMA CITY	OK	OK	GREENE, President	OLMS Only	08/06/2007	N	\$100	\$55,955	13	3
420-13286-08			INDICTMENT CITATIONS JUDICIAL DISTRICT	18 U.S.C. 691	18 U.S.C. 1001	Western Oklahoma	Western Oklahoma	PROSECUTOR						
420-13286-08			COMMUNICATIONS WORKERS AFL-CIO LU 6127	MIDLAND	TX	TX	CARY Bookkeep Office Sec	OLMS Only	02/01/2007	N	\$7,500	\$25,287	13	60
420-13286-08			INDICTMENT CITATIONS JUDICIAL DISTRICT	Western Texas	SOUTH PITTSBURG	TX	DUDLEY, Ex Secretary Treasurer	OLMS Only	02/02/2007	N	\$400	\$0	13	8
420-13286-08			INDICTMENT CITATIONS JUDICIAL DISTRICT	29 U.S.C. 501(c)	Northern Alabama	Northern Alabama	Northern Alabama	PROSECUTOR						

OFFICE OF LABOR-MANAGEMENT STANDARDS CONVICTIONS 10/01/2006 - 09/30/2007													
DATE DO NO. INO	CASE PR	UNION	LOCATION		ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y DTN	FINE	RESTITUTION	508 BAR	
			CITY	CITY								YEARS	MONTHS
440-00998-08	LU 83759	COMMUNICATIONS WORKERS AFL-CIO	CRYSTAL SPRINGS	MS	TX	Ex Other Officer	OLMS Only	09/01/2007	N	\$0	\$287	13	0
INDICTMENT CITATIONS: 29 U.S.C. 438(c) JUDICIAL DISTRICT: Southern Mississippi													
440-07091-08	BR 2464	LETTER CARRIERS, NAT'L ASN AFL-CIO	THIBODAUX	LA	TX	TAYLOR, Ex President	OLMS Only	09/10/2007	N	\$500	\$2,951	13	0
INDICTMENT CITATIONS: 29 U.S.C. 438(b) JUDICIAL DISTRICT: Eastern Louisiana													
440-07095-08	LU 928	TEAMSTERS	HOUSTON	TX	TX	CRAWLEY, Ex President	Multiple	05/25/2007	Y	\$0	\$121,478	13	78
INDICTMENT CITATIONS: Other Federal JUDICIAL DISTRICT: Southern Texas													
440-07143-08	LU 727	SECURITY POLICE, FIRE PROOF IND	BROWNSVILLE	TX	TX	GARCIA, Ex President	OLMS Only	09/12/2007	N	\$0	\$0	0	0
INDICTMENT CITATIONS JUDICIAL DISTRICT: Local Prosecutor Texas													
440-07154-08	LU 1316	LONGSHOREMEN'S ASN AFL-CIO	BEAUMONT	TX	TX	PRICE, Ex Business Manager	OLMS Only	06/22/2007	N	\$0	\$11,804	13	0
INDICTMENT CITATIONS: 29 U.S.C. 501(c), 29 U.S.C. 501(c), 29 U.S.C. 501(c) JUDICIAL DISTRICT: Eastern Texas													
440-07187-08	LU 131081	STEELWORKERS AFL-CIO	SIMSBORO	LA	LA	BURCH, 13 Ex Business Office Sec	OLMS Only	06/18/2007	N	\$0	\$0	3	0
INDICTMENT CITATIONS JUDICIAL DISTRICT: Western Louisiana													
510-06374-08	LU 720	PAINTERS AFL-CIO	BLITTE	MT	MT	KENNEDY, Ex Secretary-Treasurer	OLMS Only	02/01/2007	N	\$100	\$15,612	0	5
INDICTMENT CITATIONS: 29 U.S.C. 438(c) JUDICIAL DISTRICT: Montana Montana													

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DATE	CASE NO	PR NO	UNION	LOCATION CITY	ST	SUBJECT	JOINT INV	CONVICTION DATE	TRIAL Y OF N	FINE	RESTITUTION	504 BAR YEARS		INVESTIGATOR
												CONFIN	SUPERV	
OFFICE OF LABOR-MANAGEMENT STANDARDS CONVICTIONS 10/01/2006 - 09/30/2007														
520-12392-06	GOVERNMENT EMPLOYEES AFL-CIO	LU 1662	FT HUACHUCA	AZ	SUAREZ, President	OLMS Only	12/14/2006	N	\$100	\$27,465	13	0	60	
INDICTMENT CITATIONS: 29 U.S.C. 501(c) 29 U.S.C. 501(c) 29 U.S.C. 501(c)														
JUDICIAL DISTRICT Arizona Arizona														
520-12464-06	LETTER CARRIERS, NAT'L ASN AFL-CIO	BR 704	TUCSON	AZ	JOHNSON, Ex Secretary-Treasurer	OLMS Only	10/02/2006	N	\$100	\$15,000	13	6	60	
INDICTMENT CITATIONS: 29 U.S.C. 501(c)														
JUDICIAL DISTRICT Arizona Arizona														
520-12590-06	GOVERNMENT EMPLOYEES AFL-CIO	YUMA	YUMA	AZ	BUSECK, Ex Secretary-Treasurer	OLMS Only	09/07/2007	N	\$0	\$5,000	3	0	0	
INDICTMENT CITATIONS: Other Local Other Local														
JUDICIAL DISTRICT Local Prosecutor Arizona														
520-12596-06	SERVICE EMPLOYEES AFL-CIO	LOS ANGELES	LOS ANGELES	CA	HUMPHRIES, President	OLMS Only	12/15/2006	Y	\$0	\$36,463	0	6	6	
INDICTMENT CITATIONS: Other Local														
JUDICIAL DISTRICT Local Prosecutor California														
520-12624-06	SERVICE EMPLOYEES	LOS ANGELES	LOS ANGELES	CA	HUMPHRIES, Ex President	Multiple	05/14/2007	N	\$500	\$5,149	13	0	60	
INDICTMENT CITATIONS: 29 U.S.C. 501(c) 18 U.S.C. 2 18 U.S.C. 371														
JUDICIAL DISTRICT Central California														
520-09320-06	CARPENTERS IND	LAS VEGAS	LAS VEGAS	NV	ANDREWS, Bookkeeper/Office Sec	CIG	03/23/2007	N	\$0	\$40,087	13	6	5	
INDICTMENT CITATIONS: 29 U.S.C. 501(c)														
JUDICIAL DISTRICT Nevada Nevada														
520-09755-06	SHEET METAL WORKERS AFL-CIO	LAS VEGAS	LAS VEGAS	NV	STONE, Ex Bookkeeper/Office Sec	CIG	04/24/2007	N	\$0	\$10,000	13	0	2	
INDICTMENT CITATIONS: Other Local														
JUDICIAL DISTRICT														

OLMS RESTITUTION ORDERS

Mr. Obey: Does all of the money (\$32 million) involve restitution to unions or does it involve restitution to other entities such as insurance companies, municipalities, and other employee benefit funds?

Ms. Chao: As mentioned above, the \$32 million figure cited in the testimony was inaccurate. OLMS recordkeeping systems, including the Case Data System, do not track the identity of the entity to which restitution is ordered to be paid.

Mr. Obey: In addition, for the record, please provide a breakdown of the entities for which the \$32 million in restitution was ordered.

Ms. Chao: As mentioned above, the \$32 million figure cited in the testimony was inaccurate. OLMS recordkeeping systems, including the Case Data System, do not track the identity of the entity to which restitution is ordered to be paid.

COMBUSTIBLE DUST STANDARD

Mr. Obey: On February 7th there was a catastrophic explosion at the Imperial Sugar Plant in Savannah, Georgia. Twelve workers are now dead, and 11 are still in critical condition. From all reports the explosion was a result of combustible dust, a well-recognized hazard in this industry.

In 2006, following the investigation of other fatal dust explosions, the Chemical Safety Board (CSB) issued a report that found that there are no existing comprehensive federal standards to prevent combustible dust explosions. The CSB recommended that OSHA issue a comprehensive standard to prevent these explosions in the future and to conduct a special emphasis program of industry where combustible dust hazards are present.

Secretary Chao, why has the Department of Labor ignored the CSB's recommendation to issue a standard on combustible dust? If it's a matter of resources, why haven't you requested additional funds for the OSHA standards program?

Ms. Chao: All of us at the Department of Labor extend our sympathy to the Savannah community, the victims of the Imperial Sugar tragedy and to their families. OSHA continues to investigate the Savannah accident. The results of the investigation and an analysis of the evidence will help us better understand how to most effectively protect employees from combustible dust hazards.

Let me emphasize that the Department has not ignored the CSB's recommendations and in fact has implemented most of them. The Department,

and more specifically OSHA, take recommendations from the CSB very seriously, and OSHA has not ruled out future rulemaking to address combustible dust hazards. At this time, OSHA is addressing combustible dust hazards in multiple ways: strong enforcement of existing standards through a National Emphasis Program (NEP), additional training for its enforcement personnel, the creation and dissemination of guidance and educational materials for affected employers and employees, and cooperative ventures with stakeholders. Many of these efforts began before the accident occurred at Imperial Sugar. For example, OSHA's current NEP for combustible dust is modeled on a Special Emphasis Program on combustible dust that its Philadelphia region implemented in 2004.

Several existing OSHA standards already address aspects of the risks associated with combustible dust, including those covering dust accumulations, electrical safety, powered industrial trucks, emergency action plans, and hazard communication. In addition, OSHA is empowered by Section 5(a)(1) General Duty Clause of the OSH Act to cite employers for serious hazards that are recognized by the industry but are not covered by existing OSHA standards.

Mr. Obey: In the wake of the Imperial Sugar explosion and the deaths of 12 workers, will the Department of Labor now commit to developing and issuing a combustible dust standard?

Ms. Chao: A number of OSHA standards already address aspects of the risks associated with combustible dust. The investigation at Imperial Sugar may determine that Imperial Sugar was not in compliance with existing OSHA standards that limit accumulations of combustible dust and control ignition sources in areas where such dust is found. One of the purposes of OSHA's Combustible Dust NEP is to enable the agency to gather information that will inform us in our future consideration of a standard. While the Department and OSHA continue to consider options for rulemaking, we will actively pursue enforcement efforts through the NEP, along with outreach, training, the creation and dissemination of guidance and educational materials, and cooperative ventures with stakeholders.

OSHA REPORT ON STATUS OF KEY RULES

Mr. Obey: OSHA has missed all of the deadlines for developing standards that it has set out in its regulatory agendas over the past 7 years, except for those deadlines which were imposed by a court. In last year's bill, we directed the agency to provide the committee detailed reports on the status of key rules, and the expected timeframes for meeting key benchmarks in the standard setting process. The first report is due on March 25. Will the Department of Labor commit to fulfilling the requirements under last year's bill and provide the report on OSHA standards by March 25?

Ms. Chao: OSHA will provide a detailed report on the status of key rules, and the expected timeframes for meeting key benchmarks in the standard-setting process. This report is undergoing final review and approval and will be provided to the Committee as soon as the review is completed.

OSHA FOLLOW UP ON ERGONOMIC HAZARD ALERT LETTERS

Mr. Obey: OSHA reports that it has issued 593 hazard alert letters to notify employers about ergonomic hazards. The agency says it is now following up those letters to see if action was taken. A directive was issued last April for area offices to follow-up with each of the employers who received a letter to determine what action had been taken. Please provide for the record, the results of that follow-up activity. How many employers has OSHA contacted?

Ms. Chao: As of March 6, 2008, approximately 628 Ergonomic Hazard Alert Letters (EHALs) have been sent to employers. OSHA had made follow-up contact with 435 of the 628 employers; the remaining 193 are still being evaluated. Those employers have been asked to provide information on the efforts and progress they have made in addressing the ergonomic hazards identified during OSHA's inspection of the work site.

Mr. Obey: How many employers have provided required information?

Ms. Chao: We are very pleased with the response. Of the follow-ups to 435 employers, only one facility has provided an inadequate response. No facility has failed to respond.

Mr. Obey: What number have abated identified hazards?

Ms. Chao: Of the follow-ups to 435 employers, 28 were out of business, and 341 have informed us that they have either abated the hazards or are implementing a process which will address the hazards. Three sites have received second EHALs and OSHA is still evaluating the responses of 55 sites.

Mr. Obey: How many follow-up inspections have been conducted?

Ms. Chao: Through March 6, 2008, OSHA has initiated eight follow-up ergonomic inspections. Another 20 onsite follow-up contacts were made during unrelated inspections. For example, if a site was included in OSHA's Site Specific Targeting (SST) program, the employer's efforts to address the issues identified in the EHAL were evaluated onsite during the SST inspection instead of through the phone/fax procedures set forth in the EHAL policy.

Mr. Obey: What are the results of these follow-up inspections?

Ms. Chao: Of the eight follow-up inspections, five facilities were found to have made enough improvement to determine that they had made a satisfactory response or were making significant progress toward a satisfactory response. Two of the eight companies were sent a second EHAL. The response of the remaining facility is being evaluated.

MSHA STAFFING

Mr. Obey: Please provide an update for the MSHA staffing table on page 732 of Part 7 of the Hearings on the FY 2008 President's request. Please show both the number of budgeted full-time equivalent positions and the number of positions actually filled at the close of the fiscal year 2007 and the year-to-date information for fiscal year 2008, indicating totals for MSHA as a whole and individual totals for the coal mine safety and health, the metal and nonmetal mine safety and health, and the technical support budget activities.

Ms. Chao: The table below shows budgeted FTE, the number of filled positions at end-of-year, and the current number of filled positions for FY 2008.

Fiscal Year	Total MSHA		Coal Mine Safety and Health		Metal and Nonmetal Mine Safety and Health		Technical Support	
	Budgeted FTE	Filled at EOY	Budgeted FTE	Filled at EOY	Budgeted FTE	Filled at EOY	Budgeted FTE	Filled at EOY
2000	2,317	2,258	1,233	1,200	510	464	257	255
2001	2,357	2,323	1,233	1,169	550	526	257	262
2002	2,310	2,181	1,141	1,090	589	529	255	259
2003	2,264	2,198	1,110	1,080	609	564	255	255
2004	2,269	2,158	1,071	1,014	582	536	220	218
2005	2,187	2,151	1,043	1,003	543	544	209	223
2006	2,136	2,090	1,016	1,001	543	519	200	209
2007	2,314	2,267	1,186	1,175	543	530	200	203
2008 est ^{1/}	2,306	2,259	1,186	1,149	543	542	200	194

^{1/} On-board count as of February 29, 2008.

Note: The 2,259 figure does not account for vacancies that are in the hiring process but not yet on the agency's rolls, including 26 in Coal Mine Safety and Health. Furthermore, MSHA intends to continue to replace all vacancies created through attrition in its enforcement ranks.

Mr. Obey: How many inspectors in MSHA are in a "trainee" status? How long does it take for an inspector to be fully trained and how does this impact on the overall inspection plan, particularly for coal mine inspections where there has been a large increase in positions in over the last two years?

Ms. Chao: As of February 29, 2008, there are 209 Coal Mine Safety and Health (CMS&H) and 58 Metal and Nonmetal Mine Safety and Health

(MNMS&H) enforcement personnel enrolled in 19 inspector training classes, with graduations scheduled to occur from 3/13/08 through 5/1/09. It generally takes between 12-18 months to fully train a CMS&H or MNMS&H enforcement new hire. This impacts MSHA's 100 Percent Inspection Plan, in that during the time that new hires are in training, other enforcement personnel must work overtime and take on additional travel to complete inspections where needed. As enforcement personnel graduate and receive their Authorized Representative cards, the amount of overtime and travel will decrease.

OSHA REFERRALS FOR CRIMINAL PROSECUTION

Ms. DeLauro: I understand that as of the end of 2007, 92% of the inspections in OSHA's Enhanced Enforcement Program (EEP) involved fatalities. This means that there were a total of over 2000 fatalities involving employers with extremely serious violations. However, the Department of Labor only referred 12 cases to the Justice Department for criminal prosecution under the OSH Act in FY 2006. There were only 10 referred in both FY 2004 and 2005. Why are so few of these horrendous cases treated by OSHA as criminal violations and referred to the Justice Department? What steps are you willing to take to change this unacceptable situation?

Ms. Chao: OSHA consults closely with the U.S. Attorney's office in making determinations of the necessity and likely success of a criminal referral. OSHA has referred 64 cases to the Department of Justice since 2001, more than any previous Administration in the agency's history. It is the Department of Labor's policy to evaluate all OSHA violations that contribute to workplace fatalities for potential referral to the Department of Justice for prosecution. However, criminal prosecution for violations of OSHA standards that cause the death of an employee is appropriate only for willful violations. OSHA conducts thorough evaluations of each violation, and in many cases has determined that fatalities are not the result of a willful violation of an OSHA standard. In some instances, OSHA found that workplace fatalities were the result of willful violations, but was unable to provide the necessary quantity and quality of evidence for a successful criminal referral.

Ms. DeLauro: According to DOL, as of October 17, 2007, DOL has referred to DOJ since 1971 a total of 205 cases for potential prosecutions. (There may have been other cases prior to 1978, but DOL only acknowledges 4 such cases between 1973 and 1977.)

Please indicate the total number of cases for which the length of time – in 1-year intervals (i.e. less than 1 year, 1, 2, 3, 4, 5 or over 5 years) – which DOJ has required in order to decide whether to accept or decline the cases. For example:

Time required for decision	# cases
> 1 year	25 cases
1-2 years	61 cases

Ms. Chao: Most of our records do not contain enough information to respond to this request. Based on records of the 60 cases where that information exists, the following data is reported for the time period of FY 1978 to present:

Time required for decision	# cases
<1 year	27
1-2 years	17
2-3 years	11
3-4 years	3
>4years	2

Ms. DeLauro: For all cases referred in each year beginning in 1987, please provide both the average and median number of months required for DOJ decision.

Ms. Chao: The median number of months is 12; the average is 14.3 months.

Ms. DeLauro: When either conviction or pleas resulted in sentences to imprisonment, please indicate the number of individuals who have served such sentences, including corporate owner, corporate officer, non-corporate owner, other.

Ms. Chao: The Department of Labor does not maintain that information.

Ms. DeLauro: Finally, in how many cases has the DOJ provided assistance to state prosecutors in securing indictments/information, irrespective of outcomes (please indicate total number, by state, beginning 1977:

-- prosecutions under state OSHA plan equivalents of federal criminal charges under the OSHA Act,

-- other state criminal prosecutions for worker death (homicide, manslaughter, reckless endangerment, etc.)

Ms. Chao: We do not maintain that information in this Department; however, I can assure you that OSHA frequently cooperates with state prosecutors in investigating industrial accidents.

STANDARD SETTING FOR COMBUSTIBLE DUST AND DIACETYL

Ms. DeLauro: In FY 2007, we asked you to report to us regularly about your issuance of standards on pandemic flu and diacetyl, among other hazards. Since then, we have also seen yet another horrific explosion involving combustible dust, which has so far killed 12 workers in Georgia. However, we have still received no hard and fast commitment from OSHA for issuance of a new standard on diacetyl or pandemic flu, nor any hard and fast commitment to issue a standard to prevent dust explosions in the industries outside of grain dust where OSHA's standard has proven so effective. OSHA's refusal to issue a standard flies in the face of the specific recommendations for such a standard from the US Chemical Safety Board.

When is OSHA going to take immediate action to issue standards on these critical issues of worker health and safety, before dozens or more workers are killed or sickened?

Ms. Chao: OSHA has taken aggressive action over the past few years to address these important health and safety issues. Regarding diacetyl, OSHA announced its intent to engage in rulemaking for food flavorings containing diacetyl in the Fall 2007 Regulatory Agenda. To help focus its research efforts to support rulemaking, OSHA held stakeholder meetings to solicit issues and concerns from union and business representatives. OSHA expects to begin the Small Business Regulatory Enforcement and Fairness Act (SBREFA) review process in Spring 2008 and will expedite development of a proposed rule after receiving the recommendations from the SBREFA report. The report required by Public Law 110-161 that addresses this issue has been forwarded to the Committee.

OSHA was petitioned by a number of union groups to issue an emergency temporary standard (ETS) for pandemic influenza. However, after careful consideration, the agency denied the petition because we could not legally support an ETS for a hazard that does not actually exist at this point. Instead, OSHA believes that developing guidance, which can be readily modified as we learn more about the potential for a pandemic, is the most appropriate and effective course of action at this time. Last year, OSHA published general guidance to employers for preparing for a pandemic, and a Safety and Health Bulletin containing more comprehensive guidance for health care employers. Currently, OSHA is working with the Department of Health and Human Services (HHS) to develop *Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza*, which will provide employers with a methodology and recommendations for calculating workplace stockpiling needs for respirators and facemasks. OSHA and the Department are also coordinating activity with other federal agencies under the President's National Strategy for Pandemic Influenza. The report required by Public Law 110-161 that addresses this issue has been forwarded to the Committee.

On combustible dust, OSHA is considering the recommendation of the Chemical Safety Board to develop a comprehensive standard, as well as a Petition for an ETS recently filed by two unions. While evaluating regulatory approaches, OSHA is also addressing the combustible dust hazards through a multi-faceted approach, including the strong enforcement of existing standards, outreach, training, the creation and dissemination of guidance and educational materials, and cooperative ventures with stakeholders.

AMERICAN TIME USE SURVEY AND FY 2009 BUDGET

Ms. DeLauro: Launched in 2003, the American Time Use Survey (ATUS) is an annual household survey that measures how people divide their time among life's activities, including caring for children and sick adults, cleaning the house, working, recreating, and shopping. I am concerned that the Administration has proposed eliminating the American Time Use Survey in FY 2009. The survey is unique and essential for so many researchers inside and outside the federal government who want to understand the changing lives of American families, analyze economic growth, and assess and develop economic policy. Without the ATUS, we cannot fully evaluate the effects of policies – childcare tax credits, education subsidies, TANF, and others – that are designed in part to alter recipients' behavior. At a time when the economy is faltering, the need for good data is imperative.

At a minimum, the Bureau of Labor Statistics needs \$4.3 million to keep the ATUS ongoing. Is the Administration willing to work with the Subcommittee on a resolution to sustain the ATUS and all the BLS key surveys?

Ms. Chao: The Administration is willing to work with the Subcommittee on these sensitive issues, within the overall funding levels requested in the 2009 President's Budget. As articulated in the Department's 2009 Congressional Justification, the Administration made the decision to eliminate the ATUS in order to partially offset the rising costs of the Current Population Survey, a Principal Federal Economic Indicator. Eliminating the ATUS - one of BLS's newest and lowest priority surveys – allows BLS to focus its resources on higher priority programs that protect the accuracy and reliability of the monthly data on the Nation's labor force.

PROPOSED H-2A REGULATIONS

Ms. DeLauro: Virtually every report on farmworkers for the last 100 years has said that we must modernize labor relations and improve wages and working conditions to attract and retain workers in farm jobs. Farmworkers work for low wages in jobs prone to injury. Farm work is exempt from the Fair Labor Standard Act's overtime provisions and some child labor protections and the protections of most of our federal workplace safety laws. There is evidence

across the country that farmworkers continue to struggle to collect their wages and that there is little oversight on H-2A employers.

In recent years, our broken immigration system has essentially prevented legal immigration into agriculture and instead has allowed agricultural employers to hire undocumented workers at will, so that now more than one-half the farmworkers in the country are undocumented. The H-2A guestworker program approves almost every application by employers but only a tiny percentage of agricultural employers have chosen to apply. Your Department is now proposing to undermine the current wage rates under the H-2A program, remove government oversight in the name of streamlining, end the recruitment requirements of long standing, end the obligation to provide housing, and make other changes that could amount to a cheap foreign labor policy. These new rules seem to be tilted heavily towards the interests of corporate farms and large farm labor contractors and will do little to improve the lives of farmworkers or to ensure that foreign workers do not undercut the wages and working conditions of domestic workers.

Secretary Chao, your proposed H-2A regulation would change the wage formula. Employers would be permitted to use the four tier wage level in the Foreign Labor Certification Data Center. For each job and geographical area there are four "wage levels." Level I, Level II, Level III and Level IV. I understand that these wage levels are not related to experience or skill but rather are based on an arithmetic formula.

Isn't it true Secretary Chao that unless the job is classified at Level III or higher, your plan will allow workers to be brought into the U.S. that are paid less than the average wage for workers in that occupation and location? Why doesn't that adversely affect US workers?

Ms. Chao: The Department has proposed using data from the Occupational Employment Statistics (OES) program to determine the Adverse Effect Wage Rate (AEWR) for the H-2A program. Using OES data to calculate H-2A wage rates would provide much more refined wage rates that are precisely tailored by locality, occupation, and skill level. Whether workers are classified at Level I, Level II, Level III, or Level IV, the applicable wage rate will closely approximate the average wage paid to other workers for specified jobs in the same location, occupation, and skill level.

OES data is currently used to determine legally required wage rates for several other temporary worker programs because it provides wage rates that are tailored to the specific occupation, skill level, and geographic locality of job openings. The U.S. Department of Agriculture (USDA) survey data that is currently used to calculate the AEWR does not provide such detailed and precise wage rate data, and is not used by any other temporary worker program. Although the USDA survey was the best data available to the Department when the current AEWR

methodology was adopted 20 years ago, the OES program has since become the preeminent U.S. government data collection instrument for wage information.

The current methodology for calculating the AEW is particularly ill-suited to providing precise wage rates. The current AEW is based on data from the USDA Farm Labor survey. USDA collects wage rate data on hired farm workers for 18 geographical regions and from that data calculates the arithmetic mean wage rate for crop workers, livestock workers and crop and livestock workers combined. The current AEW, published by DOL, is the arithmetic mean of the combined crop and livestock worker rate for the region, as calculated by USDA. This broad averaging necessarily means that many workers are allowed to be offered a wage less than their occupation, skill level, and geographic location would otherwise demand. It also means that in some geographic locations wage rates are artificially inflated, resulting in farmers opting out of the H-2A program altogether and instead resorting to labor alternatives such as workers without proper documentation who, as previously noted, frequently are paid below-market wages. This hurts U.S. workers. The use of OES data would allow the Department to make substantial progress in solving these problems, providing wage rates by occupation and skill level that are precisely tailored to reflect wages in more than 500 discrete local labor markets.

Precise wage rates are important in the H-2A program to protect U.S. workers. When legally required wage rates for job openings are below the prevailing rate for the occupation, skill and locality involved, the wages of similarly situated U.S. workers may be driven down. On the other hand, when legally required wage rates are set too high for the occupation, skill and locality involved, farmers may not use the H-2A program and instead may seek alternative sources of labor, including hiring (either knowingly or unknowingly) workers without proper documentation, who are frequently willing to accept payment off the books or at substandard rates, and who may also be afraid to assert their legal rights. The United States Supreme Court and several prominent members of Congress have recognized that the hiring of illegal workers adversely affects the wages and working conditions of U.S. workers.

Ms. DeLauro: If a worker is brought in at the Level I wage doesn't that usually mean that 75 to 90% of the U.S. workers in that occupation are being paid more – why won't that depress U.S. worker wages?

Ms. Chao: As the answer above explains, the applicable wage rate for H-2A workers brought in at Level I would approximate the average wage paid to other workers for the specified jobs in the same location, occupation, and skill level. The Department's proposal to use OES data to calculate the AEW for the H-2A program would provide the greatest degree of precision possible, given available data sources. H-2A wage rates that are tailored to the specific occupation, skill level, and geographic locale of job openings would better protect the wages and working conditions of U.S. workers.

One of the most important things the Department must do to ensure that the H-2A program is fully functional and protective of the wages and working conditions of U.S. workers is to set AEWs that appropriately reflect market realities and labor costs. Two decades of experience with the H-2A program have shown that, in light of the prevailing conditions in the agricultural labor market, an AEW that is set too low or too high is likely to harm U.S. workers. It is no secret that foreign workers may be willing to work for wages that are lower, and often substantially lower, than wages that are typically paid to U.S. workers. Allowing foreign workers to work at substandard wages would likely harm U.S. agricultural workers by causing them to be displaced or by forcing them to accept substandard wages in order to compete with the foreign workers. Direct harm effects of a too-low AEW may also include increased levels of unemployment among U.S. workers. Indirect effects of a too-low AEW could include worsening working conditions.

Conversely, an AEW that is artificially set too high can also result in harm to U.S. workers. If the AEW is set so high that it is seen as not reflective of actual market conditions, agricultural employers may hire undocumented foreign workers instead of participating in the H-2A program, and the resulting influx of undocumented foreign workers erodes the earnings and employment opportunities of U.S. workers in agricultural occupations. U.S. workers cannot fairly compete against undocumented workers, who may accept work at below-market wages, and who are also cheaper to employ than H-2A workers because they do not require the additional payment of other H-2A program requirements, including transportation, and housing. Although the threat of legal sanctions and attendant risks of work disruption will constrain some employers from employing undocumented workers, the greater the total cost to employers of the AEW plus all other attendant H-2A program costs as compared to the market rate for labor, the greater the likelihood is that employers will risk hiring undocumented foreign labor.

Even in those instances where the use of OES data may result in lower AEWs for H-2A workers in the short term, the Department is confident that the wages and working conditions of U.S. workers will be protected because the total costs of hiring H-2A workers are higher than the hourly AEW alone reflects, and employers focus not only on wages when making hiring decisions, but on a workers' total cost. The program requirement that employers pay for H-2A workers' transportation and lodging, as well as the administrative expense of filing H-2A applications with several different Government agencies, add substantial additional costs to the employment of H-2A workers. The additional costs beyond wages (administrative expense, transportation and lodging) associated with utilization of foreign labor under the H-2A program are an important consideration that provides significant protection for U.S. workers. It is expected that U.S. workers in similar occupations, with similar skills and working in the same locality would likely be able to command higher hourly wages than

H-2A workers and at least equivalent benefits because the additional cost considerations associated with utilization of the H-2A program provide an economic incentive for employers to seek out and hire U.S. workers instead of H-2A workers. And of course, U.S. workers also have the protection of the rule requiring agricultural employers to first attempt to recruit U.S. workers before they can employ H-2A workers.

Ms. DeLauro: If an employer is given a choice between these four wages why won't the employer invariably choose the lowest wage rate? Hasn't that been the Department's experience under the H-1B program? Isn't it true that 56% of the H-1Bs are brought in at the Level 1 wage?

Ms. Chao: The Department does not collect information in such a way that we can readily answer the question of whether 56% of the H-1Bs are brought in at the Level 1 wage. The wage level is determined by the job and skills requirements of the requested position.

DETERMINATION OF FARMWORKER WAGES

Ms. DeLauro: I see that you are proposing to use the BLS OES Survey instead of the current Department of Agriculture survey to determine farm worker wages. As I understand it, the Department of Agriculture surveys farmers to determine what their workers are paid but the OES survey does not survey any farmers – instead only surveys labor contractors. If you are attempting to protect the wages of U.S. farmworkers why would you base the wage standard on a survey that does not study farmers but instead relies on farm labor contractors?

Ms. Chao: The OES survey data covers agricultural establishments accounting for the employment of all types of hired agricultural workers, and approximately one-third of the 1.2 million hired farm workers in the U.S, according to the USDA. The OES survey is conducted by the Bureau of Labor Statistics and is the preeminent U.S. government data collection instrument for wage information. The OES survey is accurate, produces statistically valid wage rates, and has been successfully used for years by the Department of Labor in administering other temporary worker programs. The OES data represents actual wages paid to employees of businesses that provide agricultural labor services. In addition, OES wage data is categorized according to agricultural occupations that are routinely filled by H-2A workers. Because the OES data is gleaned from wages paid to employees who perform the same type of work as H-2A workers, it provides a good basis for an appropriate comparison of the wages an employer would be expected to pay a non-H-2A worker for a particular job at a comparable skill level and in a specific geographic locale.

The USDA survey, by contrast, does not gather data specifically on wages paid to farmworkers, but rather gathers aggregate data on the total amount of wages paid by employers for all types of hired agricultural work. The USDA data is then

extrapolated and averaged across several agricultural occupations (including occupations not typically available for H-2A workers) to produce just one wage for all agricultural jobs in each of 18 geographic regions. Thus, the Department has determined that OES data, rather than USDA data, provides the best approximation of the wages that should appropriately be paid to H-2A workers.

In developing the proposal, the Department examined data from the Census Bureau's Current Population Survey (CPS), which includes agricultural workers from both farm and nonfarm establishments. The CPS, a monthly survey of 60,000 households, collects information on the employment and unemployment experience of workers in the U.S. Examining the CPS data confirmed that the OES data covering wages paid by nonfarm agricultural establishments provides an effective and appropriate proxy for the wages paid directly to workers by farm operators. Estimates based on CPS data for 2006 show little difference in the mean or median earnings of agricultural workers employed by farm establishments and those employed by nonfarm establishments (the establishments within the scope of OES).

Ms. DeLauro: In the Report of the Commission on Agricultural Workers by Commissioner Phil Martin who is a leading labor economist, he says:

"Worker, farmer, and agency testimony as well as research suggest that FLCs [farm labor contractors] are practically a proxy for the employment of undocumented workers and the egregious or subtle violations of labor laws."

"The expansion of FLC [farm labor contractor] activities in the wake of IRCA has helped to lower wages and incomes in rural America."

If Professor Martin is right isn't the Department institutionalizing wage depression by relying on a survey of labor contractors to come up with its new wage standard?

Ms. Chao: OES data provides the most precise estimate available of the wages paid to similarly situated U.S. workers in each occupation, skill level, and geographic locale, as explained above. As explained above, H-2A wage rates that are tailored to the specific occupation, skill level, and geographic locale of job opening protect the wages and working conditions of U.S. workers.

The Department is aware that some FLCs have engaged in abusive employment practices in the past, and has proposed features in the new rule to curb those abuses. Specifically, the Department's proposal would require that FLCs must attest to, obtain, and maintain a surety bond, based on the number of workers employed, throughout the period the temporary labor certification is in effect, including any extensions thereof. The Department's Wage and Hour Division will have authority to make a claim against the surety bond to secure unpaid wages or other benefits due to workers under the labor certification.

PROPOSED CHANGES TO THE H-2A PROGRAM

Ms. DeLauro: The DOL is proposing far-reaching changes to the H-2A program, including reversals of some policies that have been understood to be necessary to a guestworker program for 60 years. Given that the farmworker groups and others who would like to analyze and comment meaningfully on this proposal have limited resources and many obligations, and that the DOL with enormous resources took several months to draft this proposal, is it really appropriate to limit the public comment period to 45-days?

Ms. Chao: Many of the proposed changes in the Department's NPRM have been widely and openly discussed for years as part of the public debate over immigration reform. Many of the changes to the H-2A program that have been proposed by the Department incorporate the best features of the AgJOBS legislation that has garnered strong support from farmworker advocates and agricultural employers over the last decade. Familiarity with the H-2A program should readily enable interested parties to respond to the proposed rule changes within the originally proposed comment period. However, to provide requestors additional time for any necessary refinement to contemplated comments on the rule, the Department recently published a notice in the Federal Register [73 FR 16243] announcing the public comment period would be extended until April 14, 2008.

Ms. DeLauro: Buried deep in the discussion of the proposed regulation changes (in the Wage and Hour Administration regulatory proposal on H-2A, rather than the ETA's) the proposal states that US farmworkers could be paid less than foreign guestworkers. The employer would just have to state that the U.S. worker had been hired before the application for guestworkers was filed. This is a fundamental change in the H-2A program, which has always required that employers pay US citizens and permanent residents immigrants at least as much as guestworkers are paid. Such discrimination against U.S. workers has been understood to be anathema to our basic traditions. What exactly is the purpose in allowing employers to pay guestworkers more than U.S. workers?

Ms. Chao: Your question suggests an employer can "just state" that a US worker was hired before the H-2A worker and thus would not be bound by the H-2A wage requirements. That is an incorrect reading of the H-2A program requirements. The INA requires that U.S. workers hired during the H-2A recruitment period, including workers who respond to job advertisements, must be offered and provided no less than the same wages, benefits, and working conditions that the employer offers, intends to offer, or provides to the H-2A workers. U.S. workers who were already employed by the H-2A employer before the employer sought to use H-2A workers cannot possibly be adversely affected by the subsequent hiring of H-2A workers who may be paid higher

wages. If an employer were to offer an agricultural job opportunity at a wage higher than is currently paid to an existing U.S. employee, the existing U.S. employee would have an opportunity apply for the job. If the existing U.S. employee met the qualifications, the H-2A program requires the employer to hire the employee for that position before the employer could hire an H-2A worker. The Department's enforcement policy is consistent with the Department's statutory authority to prevent adverse effects to the wages and working conditions of U.S. workers.

EMPLOYMENT TRAINING

Ms. Roybal-Allard: Three weeks ago, the North Valley Job Training Consortium, an award-winning workforce development organization in my home state of California, announced that will now be closed on Fridays because of continuing cuts to WIA programs by this Administration.

How can the Administration justify these kinds of cuts to employment training programs, particularly given the current state of our economy? What would you say to any one of the hundreds of thousands of Californians who would have been served by this center had it been fully operational, but who now will be unable to receive those critical services?

Ms. Chao: While we do not know the details of this particular organization, in general it is the responsibility of the One-Stop Operator and the Local Workforce Investment Board to manage the finances of the center, including securing contributions from One-Stop partner programs, to maintain the operation of the centers through memoranda of understanding with these programs. Because negotiating these agreements and securing contributions from partner programs have proven difficult, the Administration's Workforce Investment Act (WIA) reauthorization proposal includes provisions to strengthen the One-Stop system and its financing.

Specifically, the Administration's WIA reauthorization proposal would provide that Governors retain a percentage of the administrative funding of each of the partner employment and training programs and distribute those funds to local areas in order to fund One-Stop infrastructure costs. This would ensure more equitable and stable funding of these costs and reduce the burden of cost allocation and resource sharing at the local level.

It's also worth noting that the 2009 Budget makes a substantial investment in job training. Government-wide, the 2009 Budget invests more than \$13 billion in training and employment programs. Including Pell Grants for students pursuing training at technical or community colleges brings this total to \$23 billion.

**PARTICIPATION OF MIGRANT AND SEASONAL FARMWORKERS IN
WIA TRAINING PROGRAMS**

Ms. Roybal-Allard: For the seventh consecutive year, you have asked us to eliminate the migrant and seasonal farmworker job-training program, known by the Department as the National Farmworker Jobs Program (NFJP). You continue to state that this program is a duplication of adult WIA services provided to farmworkers through the One Stop Career Center system.

We have Department of Labor data from Program Years 2001-2006 showing how many farmworkers the NFJP trained and placed into good paying jobs.

Please provide the following data so that we can compare the NFJP data for farmworkers who utilize the WIA adult program in the One Stop system for job training and placement. Please set out the data requested by individual program year.

How many low income migrant and seasonal farmworkers were enrolled in the WIA adult job training program via One Stops for Program Years 2001 through 2006?

Ms. Chao: We do not have data showing how many migrant and seasonal farmworkers participate in the WIA Adult formula program. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to collect information on migrant and seasonal farmworkers who participate in the WIA programs.

The fact remains, however, that services provided through this program duplicate those provided under the WIA adult programs, as well as supportive services provided by other Federal programs such as Women, Infants, and Children, the Migrant Health Program, and the Rural Housing Service.

Ms. Roybal-Allard: How many of those enrolled were initially enrolled by the National Farmworkers Jobs Program operator and then subsequently co-enrolled in the One-Stop program?

Ms. Chao: We do not have data showing how many migrant and seasonal farmworkers participate in the WIA Adult formula program. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to

collect information on migrant and seasonal farmworkers who participate in the WIA programs.

Ms. Roybal-Allard: How many of those listed in Question 1 completed job training services for Program Years 2001 through 2006?

Ms. Chao: We do not have data showing how many low income migrant and seasonal farmworkers participate in the WIA Adult formula program and their corresponding performance outcomes. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to collect information on migrant and seasonal farmworkers who participate in the WIA programs.

Ms. Roybal-Allard: How many of those enrolled from PY 2001 through PY 2006 were then placed into jobs?

Ms. Chao: We do not have data showing how many low income migrant and seasonal farmworkers participate in the WIA Adult formula program and their corresponding performance outcomes. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to collect information on migrant and seasonal farmworkers who participate in the WIA programs.

Ms. Roybal-Allard: Of those placed into jobs following training, what percentage retained those jobs using your definition of retention?

Ms. Chao: We do not have data showing how many low income migrant and seasonal farmworkers participate in the WIA Adult formula program and their corresponding performance outcomes. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to collect information on migrant and seasonal farmworkers who participate in the WIA programs.

Ms. Roybal-Allard: What were their average earnings?

Ms. Chao: We do not have data showing how many low income migrant and seasonal farmworkers participate in the WIA Adult formula program and

their corresponding performance outcomes. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to collect information on migrant and seasonal farmworkers who participate in the WIA programs.

Ms. Roybal-Allard: What was the entered employment rate of those farmworkers the One-Stop WIA adult program provided with job training services from PY 2001 through 2006?

Ms. Chao: We do not have data showing how many low income migrant and seasonal farmworkers participate in the WIA Adult formula program and their corresponding performance outcomes. That is not one of the sub-categories of participants that the law provides are to be included in the performance reporting by the States (see section 136(c)(2)(F) of WIA). DOL has been exploring revisions to the participant information it collects for the WIA and other DOL job training programs. As part of this revision, DOL would expect to collect information on migrant and seasonal farmworkers who participate in the WIA programs.

PROPOSED H-2A REGULATIONS

Ms. Roybal-Allard: Virtually every report on farmworkers for the last 100 years has said that American agriculture needs to stop relying on new waves of cheap foreign labor and must modernize labor relations and improve wages and working conditions to attract and retain workers in farm jobs. Farmworkers work for low wages in jobs prone to injury. Farm work is exempt from the Fair Labor Standards Act's overtime provisions and some child labor protections and the protections of most of our federal workplace safety laws. There is evidence across the country that farmworkers continue to struggle to collect their wages and that there is little oversight on H-2A employers.

In recent years, our broken immigration system has essentially prevented legal immigration into agriculture and instead has allowed agricultural employers to hire undocumented workers at will, so that now more than one-half the farmworkers in the country are undocumented. The H-2A guestworker program approves almost every application by employers but only a tiny percentage of agricultural employers have chosen to apply. The Department of Labor is now proposing to undermine the current wage rates under the H-2A program, remove government oversight in the name of streamlining, end long standing recruitment requirements, end the obligation to provide housing, and make other changes that could amount to a cheap foreign labor policy. These new rules seem to be tilted heavily towards the interests of corporate farms and large farm labor contractors

and will do little to improve the lives of farmworkers or to ensure that foreign workers do not undercut the wages and working conditions of domestic workers.

The Department's proposed H-2A regulation would change the wage formula. Employers would be permitted to use the four tier wage level in the Foreign Labor Certification Data Center. For each job and geographic area there are four "wage levels." Level I, Level II, Level III and Level IV. I understand that these wage levels are not related to experience or skill but rather are based on an arithmetic formula.

Isn't it true that unless the job is classified at Level III or higher, the Department's plan will allow workers to be brought in the U.S. that are paid less than the average wage for workers in that occupation and location? Why doesn't that adversely affect US workers?

Ms. Chao: The Department has proposed using data from the Occupational Employment Statistics (OES) program to determine the Adverse Effect Wage Rate (AEWR) for the H-2A program. Using OES data to calculate H-2A wage rates would provide much more refined wage rates that are precisely tailored by locality, occupation, and skill level. Whether workers are classified at Level I, Level II, Level III, or Level IV, the applicable wage rate will closely approximate the average wage paid to other workers for specified jobs in the same location, occupation, and skill level.

OES data is currently used to determine legally required wage rates for several other temporary worker programs because it provides wage rates that are tailored to the specific occupation, skill level, and geographic locality of job openings. The U.S. Department of Agriculture (USDA) survey data that is currently used to calculate the AEWR does not provide such detailed and precise wage rate data, and is not used by any other temporary worker program. Although the USDA survey was the best data available to the Department when the current AEWR methodology was adopted 20 years ago, the OES program has since become the preeminent U.S. government data collection instrument for wage information.

The current methodology for calculating the AEWR is particularly ill-suited to providing precise wage rates. The current AEWR is based on data from the USDA Farm Labor survey. USDA collects wage rate data on hired farm workers for 18 geographical regions and from that data calculates the arithmetic mean wage rate for crop workers, livestock workers and crop and livestock workers combined. The current AEWR, published by DOL, is the arithmetic mean of the combined crop and livestock worker rate for the region, as calculated by USDA. This broad averaging necessarily means that many workers are allowed to be offered a wage less than their occupation, skill level, and geographic location would otherwise demand. It also means that in some geographic locations wage rates are artificially inflated, resulting in farmers opting out of the H-2A program altogether and instead resorting to labor alternatives such as workers without

proper documentation who, as previously noted, frequently are paid below-market wages. This hurts U.S. workers. The use of OES data would allow the Department to make substantial progress in solving these problems, providing wage rates by occupation and skill level that are precisely tailored to reflect wages in more than 500 discrete local labor markets.

Precise wage rates are important in the H-2A program to protect U.S. workers. When legally required wage rates for job openings are below the prevailing rate for the occupation, skill and locality involved, the wages of similarly situated U.S. workers may be driven down. On the other hand, when legally required wage rates are set too high for the occupation, skill and locality involved, farmers may not use the H-2A program and instead may seek alternative sources of labor, including hiring (either knowingly or unknowingly) workers without proper documentation, who are frequently willing to accept payment off the books or at substandard rates, and who may also be afraid to assert their legal rights. The United States Supreme Court and several prominent members of Congress have recognized that the hiring of illegal workers adversely affects the wages and working conditions of U.S. workers.

Ms. Roybal-Allard: If a worker is brought in at the Level I wage, doesn't that usually mean that 75 to 90% of the U.S. workers in that occupation are being paid more – why won't that depress U.S. worker wages?

Ms. Chao: As the answer above explains, the applicable wage rate for H-2A workers brought in at Level I would approximate the average wage paid to other workers for the specified jobs in the same location, occupation, and skill level. The Department's proposal to use OES data to calculate the AEWR for the H-2A program would provide the greatest degree of precision possible, given available data sources. H-2A wage rates that are tailored to the specific occupation, skill level, and geographic locale of job openings would better protect the wages and working conditions of U.S. workers.

One of the most important things the Department must do to ensure that the H-2A program is fully functional and protective of the wages and working conditions of U.S. workers is to set AEWRs that appropriately reflect market realities and labor costs. Two decades of experience with the H-2A program have shown that, in light of the prevailing conditions in the agricultural labor market, an AEWR that is set too low or too high is likely to harm U.S. workers. It is no secret that foreign workers may be willing to work for wages that are lower, and often substantially lower, than wages that are typically paid to U.S. workers. Allowing foreign workers to work at substandard wages would likely harm U.S. agricultural workers by causing them to be displaced or by forcing them to accept substandard wages in order to compete with the foreign workers. Direct harm effects of a too-low AEWR may also include increased levels of unemployment among U.S. workers. Indirect effects of a too-low AEWR could include worsening working conditions.

Conversely, an AEW that is artificially set too high can also result in harm to U.S. workers. If the AEW is set so high that it is seen as not reflective of actual market conditions, agricultural employers may hire undocumented foreign workers instead of participating in the H-2A program, and the resulting influx of undocumented foreign workers erodes the earnings and employment opportunities of U.S. workers in agricultural occupations. U.S. workers cannot fairly compete against undocumented workers, who may accept work at below-market wages, and who are also cheaper to employ than H-2A workers because they do not require the additional payment of other H-2A program requirements, including transportation, and housing. Although the threat of legal sanctions and attendant risks of work disruption will constrain some employers from employing undocumented workers, the greater the total cost to employers of the AEW plus all other attendant H-2A program costs as compared to the market rate for labor, the greater the likelihood is that employers will risk hiring undocumented foreign labor.

Even in those instances where the use of OES data may result in lower AEWs for H-2A workers in the short term, the Department is confident that the wages and working conditions of U.S. workers will be protected because the total costs of hiring H-2A workers are higher than the hourly AEW alone reflects, and employers focus not only on wages when making hiring decisions, but on a workers' total cost. The program requirement that employers pay for H-2A workers' transportation and lodging, as well as the administrative expense of filing H-2A applications with several different Government agencies, add substantial additional costs to the employment of H-2A workers. The additional costs beyond wages (administrative expense, transportation and lodging) associated with utilization of foreign labor under the H-2A program are an important consideration that provides significant protection for U.S. workers. It is expected that U.S. workers in similar occupations, with similar skills and working in the same locality would likely be able to command higher hourly wages than H-2A workers and at least equivalent benefits because the additional cost considerations associated with utilization of the H-2A program provide an economic incentive for employers to seek out and hire U.S. workers instead of H-2A workers. And of course, U.S. workers also have the protection of the rule requiring agricultural employers to first attempt to recruit U.S. workers before they can employ H-2A workers.

Ms. Roybal-Allard: If an employer is given a choice between these four wages why won't the employer invariably choose the lowest wage rate? Hasn't that been the Department's experience under the H-1B program, where 56% of the H-1Bs are brought in at the Level I wage?

Ms. Chao: The Department does not collect information in such a way that we can readily answer the question of whether 56% of the H-1Bs are brought

in at the Level 1 wage. The wage level is determined by the job and skills requirements of the requested position.

FARMWORKER HOUSING

Ms. Roybal-Allard: For more than 50 years, the Bracero program, which ended in 1964, and the H-2A program (formerly H-2) have required employers to provide housing to workers, and to provide it at no cost to the workers. Your proposal is to end this requirement, by allowing employers to provide housing that is charged to workers and by providing a housing “voucher” instead of housing that is not clearly defined.

Isn't it true that there is a severe shortage of decent affordable housing for farmworkers in this country and that many farmworkers live in grossly substandard housing?

Ms. Chao: There is nothing in the Department's NPRM that alters the employer's statutory obligation to provide housing to H-2A workers at no cost to the worker. The Department also has not proposed that employers be permitted to charge workers for their housing.

In the February 13, 2008, Notice of Proposed Rulemaking, the Department proposed to allow employers to provide H-2A workers a housing voucher as an additional option for employers to meet their statutory required housing obligation. The Department proposed several safeguards to ensure that the voucher option could not be abused, and that H-2A workers always receive the housing to which they are legally entitled. First, the voucher method may not be used in an area where the Governor of the State has certified that there is inadequate housing available for farm workers in the area of intended employment. Second, the voucher is not transferable and is not redeemable for cash by the employee, but rather may only be redeemed for cash paid by the employer to a party providing appropriate housing. Third, the voucher may not be used to secure housing located outside a reasonable commuting distance from the place of employment. Finally, when workers “pool” the housing vouchers to secure housing (e.g., to secure a house instead of a motel room), such pooling may not result in a violation of the applicable safety and health standards.

The proposed voucher is one way an employer may meet his obligation to provide housing. However, if acceptable housing cannot be obtained using the voucher, the employer is not relieved of his or her obligation to provide housing that meets the applicable safety and health standards. In that case, the employer must either provide or secure housing for the H-2A workers.

The proposed voucher is but one way an employer may meet his statutory obligation to provide housing. Any housing secured through a voucher would have to meet all applicable housing standards. If acceptable housing cannot be

obtained via the voucher, the employer is not relieved of his obligation to provide housing meeting all applicable safety and health standards. The Department asked for comments in the NPRM on the idea of providing a housing voucher option, an idea that was an outgrowth of the AgJOBS legislation, and asked for public comment on whether such a system should be available and how it should be structured.

Ms. Roybal-Allard: The AgJOBS legislation permits the use of a meaningful housing allowance, not a voucher of zero dollar value, but only if the governor of the state certifies that adequate housing for migrant workers is available. You have turned that around and would permit the use of a voucher unless the governor certifies that housing is not available – why won't your policy lead to H-2A workers living in substandard conditions?

Ms. Chao: See response above. The Department believes our housing voucher proposal offers more protection to farmworkers than the AgJOBS housing allowance provision as the Department's proposal would ensure that workers are provided housing meeting applicable Federal, State or local safety and health standards.

DETERMINATION OF FARMWORKER WAGES

Ms. Roybal-Allard: I see that you are proposing to use the BLS Occupational Employment Statistics survey instead of the current Department of Agriculture survey to determine farm worker wages. As I understand it, the Department of Agriculture surveys farmers to determine what their workers are paid but the OES only surveys labor contractors. If you are attempting to protect the wages of U.S. farmworkers why would you base the wage standard on a survey that does not study farmers but instead relies on farm labor contractors?

Ms. Chao: The OES survey data covers agricultural establishments accounting for the employment of all types of hired agricultural workers, and approximately one-third of the 1.2 million hired farm workers in the U.S, according to the USDA. The OES survey is conducted by the Bureau of Labor Statistics and is the preeminent U.S. government data collection instrument for wage information. The OES survey is accurate, produces statistically valid wage rates, and has been successfully used for years by the Department of Labor in administering other temporary worker programs. The OES data represents actual wages paid to employees of businesses that provide agricultural labor services. In addition, OES wage data is categorized according to agricultural occupations that are routinely filled by H-2A workers. Because the OES data is gleaned from wages paid to employees who perform the same type of work as H-2A workers, it provides a good basis for an appropriate comparison of the wages an employer would be expected to pay a non-H-2A worker for a particular job at a comparable skill level and in a specific geographic locale.

The USDA survey, by contrast, does not gather data specifically on wages paid to farmworkers, but rather gathers aggregate data on the total amount of wages paid by employers for all types of hired agricultural work. The USDA data is then extrapolated and averaged across several agricultural occupations (including occupations not typically available for H-2A workers) to produce just one wage for all agricultural jobs in each of 18 geographic regions. Thus, the Department has determined that OES data, rather than USDA data, provides the best approximation of the wages that should appropriately be paid to H-2A workers.

In developing the proposal, the Department examined data from the Census Bureau's Current Population Survey (CPS), which includes agricultural workers from both farm and nonfarm establishments. The CPS, a monthly survey of 60,000 households, collects information on the employment and unemployment experience of workers in the U.S. Examining the CPS data confirmed that the OES data covering wages paid by nonfarm agricultural establishments provides an effective and appropriate proxy for the wages paid directly to workers by farm operators. Estimates based on CPS data for 2006 show little difference in the mean or median earnings of agricultural workers employed by farm establishments and those employed by nonfarm establishments (the establishments within the scope of OES).

PROPOSED CHANGES TO THE H-2A PROGRAM

Ms. Roybal-Allard: Given that the farmworker groups and others who would like to analyze and comment meaningfully on this proposal have limited resources and many obligations, and that the DOL, with enormous resources took several months to draft this proposal, is it really appropriate to limit the public comment period to 45 days?

Ms. Chao: Many of the proposed changes in the Department's NPRM have been widely and openly discussed for years as part of the public debate over immigration reform. Many of the changes to the H-2A program that have been proposed by the Department incorporate the best features of the AgJOBS legislation that has garnered strong support from farmworker advocates and agricultural employers over the last decade. Familiarity with the H-2A program should readily enable interested parties to respond to the proposed rule changes within the originally proposed comment period. However, to provide requestors additional time for any necessary refinement to contemplated comments on the rule, the Department recently published a notice in the Federal Register [73 FR 16243] announcing the public comment period would be extended until April 14, 2008.

Ms. Roybal-Allard: The proposed regulation states that U.S. farmworkers could be paid less than foreign guestworkers as long as the employer states that the U.S. worker had been hired before the application for guestworkers was filed. This is a fundamental change in the H-2A program, which has always required

that employers pay U.S. citizens and permanent residents immigrants at least as much as guestworkers are paid. Such discrimination against U.S. workers has been understood to be anathema to our basic traditions. What exactly is the purpose in allowing employers to pay guestworkers more than U.S. workers?

Ms. Chao: Your question suggests an employer can “just state” that a US worker was hired before the H-2A worker and thus would not be bound by the H-2A wage requirements. That is an incorrect reading of the H-2A program requirements. The INA requires that U.S. workers hired during the H-2A recruitment period, including workers who respond to job advertisements, must be offered and provided no less than the same wages, benefits, and working conditions that the employer offers, intends to offer, or provides to the H-2A workers. U.S. workers who were already employed by the H-2A employer before the employer sought to use H-2A workers cannot possibly be adversely affected by the subsequent hiring of H-2A workers who may be paid higher wages. If an employer were to offer an agricultural job opportunity at a wage higher than is currently paid to an existing U.S. employee, the existing U.S. employee would have an opportunity apply for the job. If the existing U.S. employee met the qualifications, the H-2A program requires the employer to hire the employee for that position before the employer could hire an H-2A worker. The Department’s enforcement policy is consistent with the Department’s statutory authority to prevent adverse effects to the wages and working conditions of U.S. workers.

JOB CORPS STUDENT TRAINING SLOTS

Ms. Roybal-Allard: Included in the fiscal year 2007 and 2008 appropriations bills was statutory language prohibiting the Department from reducing student training slots below 44,491, the number of slots the Department operated in program year 2006 according to its FY 2007 budget request. Yet currently, the Department is operating only 43,459 training slots in Job Corps. That’s over 1,000 slots less, and equivalent to closing three Job Corps centers. Why has the Department proceeded with reducing the overall capacity of Job Corps despite a statutory requirement prohibiting these actions?

Ms. Chao: During Program Year 2007, Job Corps has been in the process of re-allocating slots from centers where the slots were consistently unfilled to centers where there is a higher demand for training slots and to centers that were closed due to Hurricane Katrina. We recently re-opened the New Orleans center and have been building up the capacity at that center. We just began the construction of interim modular buildings at Gulfport, and we intend to partially re-open that center while the existing center, which was destroyed by Hurricane Katrina, is rebuilt. The interim Gulfport Center should be completed by December of this year, and we will begin recruitment and build up with the Operating Contractor several months before the facility is completed. In addition, we plan to re-open the center at Oconaluftee at the beginning of PY08, dependent

on the Department of Interior and Department of Agriculture completing all of their transition activities. Due to the complications of changing the population served by a contractor through the procurement process, it takes a period of time to take the slots from one center and place them at others. The Office of Job Corps believes that this process will be completed and all of the slots allocated before the end of Program Year 2007.

Ms. Roybal-Allard: While Job Corps' student training slots have not been reduced, vocational training slots have been cut. The result has been Job Corps students being placed on waiting lists to receive the training they signed up for. The number of non-graduates or Job Corps former enrollees has increased 50% since PY2003 at contract centers where vocational slots have been most dramatically reduced. Given the difficulty Job Corps already faces in keeping this population engaged in their education, why would the Department promote a destructive policy that is not in the interest of the program's students?

Ms. Chao: It is not accurate to say that vocational training slots have been cut. While there may be a temporary reduction during periods where training programs are being realigned, overall, Job Corps' career technical (vocational) training slots have remained stable over the years. Job Corps' policy has always been to maintain the number of contracted career technical training slots at each center at a level that supports the center's On-Board-Strength (OBS). There have been, and will continue to be, changes to career technical programs in response to industry demands; however, each closed or reduced program is replaced with a new one with the same number of career technical slots. The new program will be aligned to industry skills/training standards in high-growth/high-demand industries. The closed programs are usually low-performing ones that prepare students for jobs in declining industry areas.

It is important to note that replacement of one program with another may take some time to implement. This can cause temporary pressure on other training programs that have to accommodate surplus students, and it may result in waiting lists. For instance, one of the National Training Contractors recently eliminated 6 of their center programs as part of their new contract, resulting in the temporary displacement of the students. Job Corps proposed a 30 day transition period to allow students to move into other trades, but the contractor did not accept the proposal. However, we normally allow a transition of 30 to 90 days when terminating one trade and replacing it with a new one so that students are not left without a career technical training program.

JOB CORPS STAFF COMPENSATION

Ms. Roybal-Allard: A comprehensive review of staff compensation conducted by the U.S. Department of Labor in 2006 revealed that a \$40 million annual funding increase would be needed to close the significant gap between Job Corps salaries and competitive market rates. The cornerstone of any education

program is the quality, morale and dedication of its staff. Why has no additional funding been included in the Administration's FY2009 budget request to address Job Corps' devastating staffing crisis?

Ms. Chao: In previous fiscal years, the Department did request and receive additional funding to help close the pay gap that was indicated by our most recent pay comparability study. We provided a pay increase to teachers and other staff in PY06 (approximately \$4.6M) and another pay increase for teachers at the beginning of PY07 (approximately \$2.4M). It was our intention to continue to make adjustments to salaries for teachers and staff, as warranted, to improve our ability to recruit and retain qualified staff in PY2008. However, the requirement to maintain 44,491 slots in the system will hamper our ability to provide additional funding in PY2008. In the FY2009 budget request, we have once again proposed that we dedicate our limited resources to improving the quality of the Job Corps program, in ways such as staff salary increases, rather than maintain slots at a level higher than we have been able to consistently fill.

JOB CORPS CONSTRUCTION NEEDS

Ms. Roybal-Allard: Included in the President's fiscal year 2009 proposed budget is \$110 million for the Job Corps' construction account, which represents a \$3 million reduction from the fiscal year 2008 level. About \$59 million of this funding is set-aside for the construction of two new Job Corps centers in Iowa and New Hampshire. As you are aware, Job Corps has over 2,200 buildings having a combined total of more than 24 million square feet. The average age of these buildings is 42 years. Based on recent architectural and engineering reviews that have been conducted at all Job Corps centers, there is a current: (1) \$100 million backlog of immediate unfunded building maintenance and repair needs; and (2) \$700+ million backlog of needs for replacement of major alteration of old buildings that are becoming unserviceable as measured by industry standards. With the backlog of existing construction needs, how will the Department address the backlog of repairs and renovations and new building construction on existing facilities with only \$50 million? Will construction projects be delayed or postponed if Job Corps' construction budget is not at a suitable level to address the backlog of needs? Please provide the Committee with an inventory of construction needs at each Job Corps center.

Ms. Chao: Job Corps has a system in place to identify, with the input of center operators and program staff, those priorities that should receive funding each program year. In accordance with the Department's Asset Management Plan, all of the deficiencies are rated to determine the impact on the facility or program and the cost/benefit of repair or replacement is analyzed. Using this process, the majority of the \$50 million will be used for repairs, renovations and building construction on existing facilities that are determined to be of the highest priority. All repairs or deficiencies that would impact the safety and/or health of students or staff are funded immediately, as are any deficiencies that would

negatively impact the environment. While Job Corps cannot schedule all projects for immediate repair, no delays or postponements are anticipated to the scheduled projects within the proposed budget.

The inventory of repair/renovation needs, by dollar amount, at each center is as follows:

Center Name	Unfunded Deficiencies	Proposed Renovation Projects	Major Alteration Projects	Total
WESTOVER	\$ 688,122	\$ 1,066,600	\$ 775,000	\$ 2,529,722
NORTHLANDS	\$ 982,921			\$ 982,921
PENOBSCOT	\$ 873,441	\$ 1,009,800		\$ 1,883,241
GRAFTON	\$ 2,975,677	\$ 3,143,000		\$ 6,118,677
NEW HAVEN	\$ 1,335,989	\$ 458,000		\$ 1,793,989
LORING	\$ 847,713	\$ 150,000		\$ 997,713
SARGENT SHRIVER	\$ 2,218,305			\$ 2,218,305
HARTFORD	\$ 148,406	\$ 3,429,800		\$ 3,578,206
EXETER	\$ 745,464	\$ 813,300		\$ 1,558,764
GLENMONT	\$ 1,377,927		\$ 27,622,400	\$ 29,000,327
EDISON	\$ 1,263,165	\$ 6,082,500		\$ 7,345,665
ARECIBO	\$ 606,371	\$ 6,376,200		\$ 6,982,571
ONEONTA	\$ 2,847,179	\$ 15,726,400		\$ 18,573,579
CASSADAGA	\$ 527,804	\$ 5,539,300		\$ 6,067,104
DELAWARE VALLEY	\$ 1,901,913	\$ 4,719,400		\$ 6,621,313
SOUTH BRONX	\$ 4,170,175	\$ 9,475,000		\$ 13,645,175
RAMEY	\$ 6,266,121	\$ 23,365,600		\$ 29,631,721
IROQUOIS	\$ 1,292,119	\$ 13,297,700		\$ 14,589,819
BARRANQUITAS	\$ 1,250,746			\$ 1,250,746
WOODSTOCK	\$ 1,193,413	\$ 7,838,700		\$ 9,032,113
BLUE RIDGE	\$ 384,316	\$ 1,698,400		\$ 2,082,716
CHARLESTON	\$ 29,077	\$ 922,000		\$ 951,077
KEYSTONE	\$ 2,712,604	\$ 8,879,800	\$ 5,584,000	\$ 17,176,404
PITTSBURGH	\$ 6,692,830	\$ 10,795,500		\$ 17,488,330
WOODLAND	\$ 838,483	\$ 4,708,890		\$ 5,547,373
POTOMAC	\$ 1,746,259	\$ 7,419,000	\$ 6,155,000	\$ 15,320,259
RED ROCK	\$ 2,056,555	\$ 11,950,000		\$ 14,006,555
OLD DOMINION	\$ 570,975	\$ 3,963,400		\$ 4,534,375
HARPERS FERRY	\$ 2,892,770	\$ 962,500		\$ 3,855,270
FLATWOODS	\$ 670,328	\$ 11,020,000		\$ 11,690,328
PHILADELPHIA	\$ 1,077,952			\$ 1,077,952
EARLE C. CLEMENTS	\$ 4,536,888	\$ 24,936,900		\$ 29,473,788
WHITNEY M. YOUNG	\$ 1,518,908	\$ 1,588,000		\$ 3,106,908
C.D. PERKINS	\$ 2,399,741	\$ 2,279,300		\$ 4,679,041
MUHLENBERG	\$ 2,149,724	\$ 327,800		\$ 2,477,524
GREAT ONYX	\$ 576,463	\$ 1,214,900		\$ 1,791,363
PINE KNOT	\$ 979,858			\$ 979,858

Center Name	Unfunded Deficiencies	Proposed Renovation Projects	Major Alteration Projects	Total
FRENCHBURG	\$ 1,081,099	\$ 797,900		\$ 1,878,999
WILMINGTON				
SATELLITE	\$ 113,488			\$ 113,488
ATLANTA	\$ 460,582		\$ 63,000,000	\$ 63,460,582
TURNER	\$ 1,402,234	\$ 11,224,600		\$ 12,626,834
KITTRELL	\$ 872,792	\$ 1,784,300		\$ 2,657,092
BRUNSWICK	\$ 650,634	\$ 8,801,000	\$ 3,631,500	\$ 13,083,134
BAMBERG	\$ 383,683	\$ 1,531,700		\$ 1,915,383
GAINESVILLE	\$ 236,149	\$ 1,501,400		\$ 1,737,549
JACKSONVILLE	\$ 153,405			\$ 153,405
GULFPORT	\$ 366,178	\$ 2,925,500		\$ 3,291,678
BATESVILLE	\$ 171,974			\$ 171,974
HOMESTEAD	\$ 919,514	\$ 5,546,500	\$ 500,000	\$ 6,966,014
MISSISSIPPI	\$ 1,550,267	\$ 6,212,400		\$ 7,762,667
MIAMI	\$ 213,032			\$ 213,032
JACOBS CREEK	\$ 329,826	\$ 2,746,600	\$ 100,000	\$ 3,176,426
LYNDON B. JOHNSON	\$ 64,745			\$ 64,745
SCHENCK	\$ 603,723	\$ 8,982,900		\$ 9,586,623
OCONALUFTEE	\$ 143,814			\$ 143,814
GADSDEN	\$ 487,435			\$ 487,435
MONTGOMERY	\$ 120,932			\$ 120,932
BENJAMIN L. HOOKS	\$ 547,397			\$ 547,397
ATTERBURY	\$ 1,576,605	\$ 4,369,300		\$ 5,945,905
CINCINNATI	\$ 875,027		\$ 22,250,000	\$ 23,125,027
DETROIT	\$ 569,408			\$ 569,408
DAYTON	\$ 1,287,836			\$ 1,287,836
JOLIET	\$ 3,675,208	\$ 1,371,200		\$ 5,046,408
GERALD R. FORD	\$ 319,584		\$ 21,478,000	\$ 21,797,584
FLINT/GENESEE	\$ 964,890			\$ 964,890
HUBERT H. HUMPHREY	\$ 1,979,636			\$ 1,979,636
BLACKWELL	\$ 831,023			\$ 831,023
GOLCONDA	\$ 2,090,948	\$ 330,500	\$ 4,491,900	\$ 6,913,348
PAUL SIMON (CHICAGO)	\$ 167,949	\$ 707,200		\$ 875,149
NORTH TEXAS	\$ 1,920,931	\$ 16,447,700		\$ 18,368,631
TULSA	\$ 319,389			\$ 319,389
GUTHRIE	\$ 262,317			\$ 262,317
DAVID L. CARRASCO	\$ 668,878			\$ 668,878
ALBUQUERQUE	\$ 1,335,776	\$ 2,340,200		\$ 3,675,976
GARY	\$ 2,665,810	\$ 27,021,200		\$ 29,687,010
ROSWELL	\$ 635,603		\$ 6,938,000	\$ 7,573,603
SHREVEPORT	\$ 1,352,094	\$ 23,811,100		\$ 25,163,194
TALKING LEAVES	\$ 118,895			\$ 118,895
LAREDO	\$ 643,012	\$ 4,428,000		\$ 5,071,012
LITTLE ROCK	\$ 321			\$ 321

Center Name	Unfunded Deficiencies	Proposed Renovation Projects	Major Alteration Projects	Total
TREASURE LAKE	\$ 1,114,182	\$ 538,400		\$ 1,652,582
CASS	\$ 1,342,571			\$ 1,342,571
OUACHITA	\$ 586,982	\$ 3,052,600		\$ 3,639,582
CARVILLE	\$ 47,543			\$ 47,543
EXCELSIOR SPRINGS	\$ 2,859,972	\$ 1,744,500		\$ 4,604,472
DENISON	\$ 537,034			\$ 537,034
ST LOUIS	\$ 702,755		\$ 22,200,000	\$ 22,902,755
MINGO	\$ 1,307,647	\$ 3,023,000		\$ 4,330,647
PINE RIDGE	\$ 175,538	\$ 1,319,000		\$ 1,494,538
FLINT HILLS	\$ 352,268	\$ 1,186,800		\$ 1,539,068
CLEARFIELD	\$ 1,870,360	\$ 17,956,200	\$ 12,329,600	\$ 32,156,160
KICKING HORSE	\$ 270,556			\$ 270,556
COLBRAN	\$ 815,614	\$ 1,422,600		\$ 2,238,214
WEBER BASIN	\$ 198,607	\$ 3,375,200		\$ 3,573,807
ANACONDA	\$ 1,229,524	\$ 4,495,000		\$ 5,724,524
BOXELDER	\$ 1,448,801	\$ 2,323,000		\$ 3,771,801
TRAPPER CREEK	\$ 400,066			\$ 400,066
QUENTIN BURDICK	\$ 877,282			\$ 877,282
LOS ANGELES	\$ 215,687			\$ 215,687
SAN JOSE	\$ 1,687,047		\$ 692,000	\$ 2,379,047
HAWAII	\$ 267,206	\$ 586,300		\$ 853,506
PHOENIX	\$ 498,850			\$ 498,850
INLAND EMPIRE	\$ 545,361	\$ 2,114,200		\$ 2,659,561
SACRAMENTO	\$ 523,878	\$ 4,469,000		\$ 4,992,878
SIERRA NEVADA	\$ 3,009,543	\$ 8,860,000		\$ 11,869,543
FRED ACOSTA	\$ 684,333	\$ 654,400		\$ 1,338,733
SAN DIEGO	\$ 45,437	\$ 1,948,590		\$ 1,994,027
HAWAII/MAUI	\$ 569,638		\$ 3,632,000	\$ 4,201,638
LONG BEACH	\$ 115,487			\$ 115,487
TREASURE ISLAND	\$ 6,090,777	\$ 5,133,800		\$ 11,224,577
SPRINGDALE	\$ 34,737	\$ 4,303,900		\$ 4,338,637
TONGUE POINT	\$ 3,187,505	\$ 1,001,500		\$ 4,189,005
CASCADES	\$ 2,991,303	\$ 2,832,200		\$ 5,823,503
COLUMBIA BASIN	\$ 684,234	\$ 7,492,600	\$ 5,214,000	\$ 13,390,834
FORT SIMCOE	\$ 822,106		\$ 3,178,000	\$ 4,000,106
CENTENNIAL	\$ 142,380			\$ 142,380
ANGELL	\$ 279,733			\$ 279,733
CURLEW	\$ 1,496,665			\$ 1,496,665
TIMBER LAKE	\$ 1,403,070	\$ 5,298,700	\$ 5,241,000	\$ 11,942,770
WOLF CREEK	\$ 2,310,227	\$ 7,880,500		\$ 10,190,727
ALASKA	\$ 412,171	\$ 2,552,600		\$ 2,964,771
Total	\$ 144,635,427	\$ 423,603,480	\$ 215,012,400	\$ 783,251,307

EEOICPA OMBUDSMAN

Mr. Udall: Secretary Chao, in both the 2007 Annual Report to Congress from EEOICPA Ombudsman and the two annual reports preceding it, specific recommendations were outlined to improve the system and to assist claimants. Can you list all concrete, specific instances of your Department enacting those recommendations?

Ms. Chao: Since the publication of the Ombudsman's *First Annual Report to Congress* in 2005, the Department of Labor (DOL) has been responsive in utilizing the concerns, questions, and recommendations presented by the Ombudsman to enhance our services to claimants and to help them better understand their rights and responsibilities under the Act:

- Regarding the Ombudsman's reports of concerns that the processing of claims is taking too long, DOL devoted significant resources to the Part E backlog during 2005-2007, focusing on those workers who had filed claims under the old Department of Energy (DOE) Part D program and whose claims were already four years old when we received them. By the end of FY 2007, DOL had completed at least an initial determination on every one of the 25,000 Part E cases inherited from DOE. In March 2008, we announced that DOL has paid more than \$1 billion to more than 8,900 individuals under Part E. In 2008 we are working to clear the remaining backlogs under both Part B and Part E programs, and we expect to have a working inventory of six months or fewer cases on hand by the end of this fiscal year. For greater efficiency and speed, DOL now adjudicates all claims for benefits under Parts B and E as one claim and issues decisions that address both Parts B and E simultaneously where possible. As of March 2008, more than \$2.38 billion in federal compensation has been paid to eligible workers under Part B, and more than \$205 million has been paid in medical benefits under Parts B and E of the Act. DOL has approved benefits in more than half of both Part B and Part E cases filed for covered employment and covered illnesses, and the approval rate for claims requiring dose reconstruction is 36 percent.
- The Ombudsman's reports recount claimants' difficulty in understanding Special Exposure Cohort (SEC) classes, although they relate to Part B of the Act. As of April 2, 2008, the Department of Health and Human Services (HHS) has designated 28 SEC classes in addition to the four statutory classes, which combined, represent workers at 26 facilities. Both DOL and the National Institute for Occupational Safety and Health (NIOSH) provide information to help claimants understand the criteria for inclusion in an SEC (i.e., specified employment plus 250 work days and a specified cancer) and we conduct town hall meetings that help employees and their families understand the class definition(s) and how claims will be reviewed. As HHS designates each new SEC class, DOL issues special

procedures for claims at the affected site and takes steps to ensure that workers' claims are reviewed for potential inclusion in the SEC and rapid payments are made for those who are covered.

- Regarding the Ombudsman's reports detailing concerns about the burden of providing employment, exposure, and medical records, DOL does everything possible to assist claimants, in compliance with section 7384v of the Act. DOL contacts DOE to verify employment for claimants, and we use a DOE database for online employment verification of some claims. DOL also has a contract with the Center to Protect Workers' Rights to secure employment information for subcontractors. Additionally, DOL works with DOE's Former Worker Programs, and other contractors, to locate appropriate records that are not immediately available through DOE. Another source of information is the Social Security Administration; with a claimant's permission, we can request earnings data to verify work history.

DOL also works jointly with DOE to collect records that describe the types of toxic materials present at DOE work sites, how these materials were used, how workers were protected from those substances, and whether there were toxic exposure incidents. DOL's Site Exposure Matrices (SEM) database now houses information on 6,273 toxic substances present at 66 DOE sites, 4,170 uranium mines, 48 uranium mills, and 17 uranium ore buying stations covered under EEOICPA. DOL utilizes the SEM database, along with DOE Former Worker Program studies, occupational medical matrices that offer information about the progression of certain illnesses, and DOE Document Acquisition Request records that contain employees' radiological dose records, incident or accident reports, industrial hygiene or safety records, personnel records, job descriptions, medical records, and other records to determine causation. The Division of Energy Employees Occupational Illness Compensation (DEEOIC) uses a national network of qualified District Medical Consultants (DMCs) to assist in the evaluation of medical records, and industrial hygienists to evaluate potential workplace exposures.

While the burden of providing proof must ultimately rest on the claimant (*see* 20 C.F.R. 30.111), all the above efforts undertaken by DOL will assist claimants in proving their claims.

- In response to concerns reported about the posting of Site Exposure (SEM) information, the DEEOIC has made available a public version of the various toxic materials that are identified as having been present at the facilities in the matrix. The initial public version of the SEM was released on March 19, 2007. In addition, we have implemented an electronic process to allow the public to submit documents or other information that may be used to update the information available to our claims staff

through SEM. Information is available online about the toxic substances added to the SEM as a result of public submissions. However, given security concerns with regard to the use of “Official Use Only” DOE documents, more specific information about material use in specific facilities locations, processes, or labor categories can not be made available to the public.

- The Ombudsman’s reports have pointed to allegations of poor customer service. DOL works closely with the Ombudsman’s Office to try to immediately address and resolve such complaints and questions when they arise, and we encourage the Ombudsman to bring such issues to our attention. We continue to work with our claims staff to promote improved customer service interaction with our claimants, which is critically important in any compensation program, but especially so for EEOICPA given the age and infirmity of most of our claimants. Managers from our National Office traveled to each of our District and Final Adjudication Offices during the summer and fall of 2007 to address customer service and emphasize the importance of providing a high level of claimant assistance, especially as it relates to information and document collection. In addition, we have developed a formal training program to focus attention on the value of clearly written development letters and recommended decisions. The objective of this training is to significantly improve the overall quality and understandability of all written communication released by the program. In addition, the training ensures that nuclear workers or their families receive every possible consideration to allow for a positive result in the claims adjudication process.

Our Resource Centers (RCs) are staffed with professional customer service personnel who initiate employment verification, and help claimants complete occupational histories and claim forms. RC staff can also help identify a claimant’s potential for wage-loss benefits and assist in obtaining medical tests for impairment. Additionally, as a new service, RCs now provide one-on-one assistance to claimants and health care providers to facilitate medical benefit delivery under the EEOICPA.

DOL has also upgraded its website to provide easier access to the program’s online forms, medical billing information, regulations, procedures, final decisions, brochures, and current statistics. All DEEOIC offices strive to answer phone calls within two work days, and in 2007, we met that goal 97% of the time in our four district offices. DOL is also providing an online medical provider look-up capability that will allow claimants and other interested parties to identify physicians in their geographical area who have enrolled as participants under the EEOICPA program.

- Regarding the Ombudsman’s report of concerns that a qualified claimant’s death prior to payment of an award may nullify the claim or reduce

compensation, statutory limitations on the eligibility of survivors under Part E make it inevitable that some instances of this kind will occur, but they are rare. DOL has worked as hard as is humanly possible to prevent this scenario from occurring, as spelled out in testimony by Shelby Hallmark before the Senate Health, Education, Labor, and Pension Committee in October 2007.

- The Ombudsman also reported concerns regarding the use of Bulletin 06-10, "Illnesses that presently have no known causal link to toxic substances," in the denial of claims. Functionally, this bulletin merely serves to assist our claims staff in processing claims where we have been unable to document a linkage between an identified disease and a toxic substance. However, the bulletin does provide guidance for evaluating scientific data that may alter the findings for the program. In response to these concerns, the DEEOIC is in the process of preparing a revised bulletin that will clarify its usage and the affected diseases.
- Regarding the Ombudsman's report of concerns in 2006 about discontinuation of services by Professional Case Management (PCM), this potential problem was averted through discussion and agreement about correct billing procedures.

SPECIAL EXPOSURE COHORT

Mr. Udall: Secretary Chao, your department has issued a Final Bulletin for the Special Exposure Cohort (SEC) for claimants from the Rocky Flats facility which arbitrarily requires that claimants meet a minimum annual dose of neutron radiation. No other Department of Energy facility that received SEC status has had to meet this neutron requirement, and even if the Rocky Flat claimants do meet this arbitrary requirement, your department's Final Bulletin states that these claims must still be reviewed by NIOSH.

This is a case in where your department appears to be redefining an SEC class, which has implications for all future SEC. While you have previously stated that you will ensure EEOICPA is being administered in a fair and consistent manner, this action is yet another which gives me grave concern that the program is in fact not following its mandate to treat all claimants fairly.

Last year, you maintained that your department has no need for oversight as it administers EEOICPA. In the face of growing complaints like the one mentioned above, do you still maintain that there is no need for oversight of the program?

Ms. Chao: The procedures described in EEOICPA Bulletin No. 08-14 regarding a minimum annual dose of neutron exposure are not arbitrary nor do they add any requirement beyond that which was established in the HHS definition of the Rocky Flats SEC classes. Nor is this guidance relevant to any

other designation of employees in the SEC that are not similarly limited to those who were or should have been monitored for neutron exposure.

The classes of workers at Rocky Flats to be included in the SEC were defined by the Advisory Board on Radiation and Worker Health (ABRWH). The Secretary of HHS adopted the Board's recommended definition without change. The SEC classes were defined as those workers who were or should have been monitored for exposures to neutron doses. Since this definition is less specific than other HHS class definitions, it required the elaboration of operational criteria for the use of DOL claims staff in determining whether an individual worker was or should have been monitored for neutron dose. Two criteria for inclusion in the SEC class were established based on the NIOSH evaluation of the Rocky Flats SEC petition and consultation with NIOSH staff: 1) inclusion in the Rocky Flats Neutron Dosimetry Reconstruction Project list (which contains 5,308 names of workers), and 2) employment in a building identified as a plutonium building. Because of the possibility that an employee who was **not** on the neutron dosimetry list and was **not** assigned to one of the identified plutonium buildings, may nevertheless fall within the class of workers who "should have been monitored," DOL determined that it would also include with the SEC class anyone who was credited with sufficient neutron dose in the NIOSH dose reconstruction calculation to reach the threshold level for monitoring in at least one year during the period covered by the SEC classes (1952-1966).

Applying the guidance in the bulletin, it is plain that there will be some, albeit few, cases where the only evidence that an employee was, or should have been, monitored are contained in the dose reconstruction done by NIOSH. Because NIOSH dose reconstruction reports are highly complex and the scientific content could be misinterpreted, DOL has indicated to NIOSH that before utilizing a NIOSH dose reconstruction report as the sole basis for such an evidentiary finding, it would consult with NIOSH.

DOL's bulletin was developed after consultation with NIOSH and properly interprets the HHS definition for inclusion in the Rocky Flats SEC classes. It ensures that anyone who "was monitored or should have been monitored" for neutron dose is in fact included in the classes. Nevertheless, any claimant determined by DOL not to meet the class definition may appeal DOL's final decision to the U.S. district courts.

DOL has received intensive and continuing oversight regarding its stewardship of the EEOICPA programs, including multiple Congressional hearings, GAO audits and studies, and OIG audits and studies. We have never suggested that EEOICPA should be exempt from oversight. Further, DOL decisions (and the rules and procedures which underlie them) are subject to appeal in U.S. district court. Because, as explained above, the bulletin implementing the Rocky Flats SEC classes conforms to the HHS class definition and simply provides guidance

designed to ensure that all members of the classes are properly identified, that matter should have no bearing on the degree of oversight of these programs.

SITE EXPOSURE MATRICES

Mr. Udall: As you are aware, the SEM is a DOL database on toxic substances. I understand that the private data based includes buildings in which a toxin was present, the diseases that exposure to a toxin may result in, and job classifications for workers who may have been exposed to the toxins. DEEOICP has made available to the public a list of the toxins present at most facilities, but not the comprehensive, private data base. Why is vital claims information being withheld from the public by not making the "private version" of the Site Exposure Matrices (SEM) available for public review and input to claimants or their physicians?

Ms. Chao: The Site Exposure Matrices (SEM) is a tool that is provided to DEEOIC claims staff to assist in developing and adjudicating exposure information. As you have indicated, it does contain information concerning buildings of a facility in which a toxin was present, the diseases that exposure to a toxin may result in, and job classifications for workers who may have been exposed to the toxins. The information from SEM that is available to the public is a listing of all of the toxic substances that DEEOIC has found at a DOE facility. This information is inclusive of all the toxic substances included in the more detailed version of SEM used by the claims staff. The SEM available to the claims staff contains detail regarding specific buildings and job classifications, including information which is classified by the Department of Energy as Official Use Only (OUO) information. For national security reasons, it cannot be released in that format to the public.

The information in SEM concerning the diseases that may be caused, contributed to, or aggravated by exposure to a toxin is based on a database called "HAZMAP" that is owned by the National Library of Medicine, which is publicly available on the internet. The major difference between the information in HAZMAP and the related information in SEM is that SEM is updated more frequently and is tailored to the types of diseases and related causes for which we receive claims. We have made this portion of SEM available to the public.

EEOICPA FINAL BULLETINS

Mr. Udall: Why are Final Bulletins related to EEOICPA not published in the Federal Register and comments solicited from the public, when these bulletins are used to interpret the law?

Ms. Chao: Final Bulletins related to EEOICPA are not published in the Federal Register with a request for comments from the public because Congress, in enacting section 553 of the Administrative Procedure Act, exempted

“interpretative rules, general statements of policy, or rules of agency organization, practice or procedure” from its notice and comment requirements. The EEOICPA bulletins issued by the Department of Labor fall within this exception.

DEEOICP CLAIMS PROCESS AUDIT

Mr. Udall: Previously, you testified that your Office of Inspector General was tasked to audit the DEEOICP’s claims process. When will that audit be made public? Do you have preliminary results from the audit?

Ms. Chao: The Department of Labor’s Office of Inspector General (OIG) was tasked with conducting an audit of the claims process performed by the Division of Energy Employees Occupational Illness Compensation (DEEOIC). The audit involved interviews with several DEEOIC personnel from each office regarding the claims process. The audit also included a review of files at all DEEOIC offices, including the National Office in Washington, D.C., the district offices in Jacksonville, Florida, Cleveland, Ohio, Denver, Colorado, and Seattle, Washington, and the corresponding Final Adjudication Branch offices. It is expected that OIG will complete the audit and release the preliminary results by May 2008.

CLAIMS AFFECTED BY REVISIONS TO NIOSH SCIENTIFIC METHODOLOGY

Mr. Udall: Each time NIOSH revises its scientific methodology your department reopens the claims affected and sends them back to NIOSH for another dose reconstruction. How many claims have been reopened for this reason? How much has it cost?

Ms. Chao: It is not possible for the program to evaluate the specific reasons for a reopening based on our existing claim status data. Our Electronic Case Management System coding merely tracks that the case has been reopened and either returned back to the District Office or the Final Adjudication Branch for new action. There can be any number of various reasons for a particular claim to be reopened. We do not have a basis for estimating the portion of DEEOIC costs associated with reopening the cases specific to NIOSH scientific methodology changes, and we cannot estimate NIOSH costs.

PAYMENT OF BENEFITS UNDER EEOICPA PART E

Mr. Udall: EEOICPA requires, under Part E, that a claimant provide a preponderance of evidence to prove their claim. The statute reads: “toxic exposure was as least as likely as not a **significant factor** in contributing to, aggravating or causing a disease.” Please explain the legal rationale used to interpret the statute to mean a preponderance of the evidence.

Ms. Chao: EEOICPA provides benefits only to claimants who meet the criteria specified in the statute (*See*, for example, 42 U.S.C. 7384n (a), 42 U.S.C. 7384n (b)), and is otherwise silent with respect to burdens of proof. In the absence of a statutory provision, the Administrative Procedure Act, as construed by the Supreme Court in *Director, Office of Workers' Compensation Programs, Department of Labor v. Greenwich Collieries*, 512 U.S. 267 (1994), places the burden of persuading a decision-maker on the party advancing a claim. Accordingly, the regulations at 20 C.F.R. § 30.111 provide that:

(a) Except where otherwise provided in the Act and these regulations, the claimant bears the burden of proving by a preponderance of evidence the existence of each and every criterion necessary to establish eligibility under any compensable claim category. . .

Thus, a claimant seeking to receive compensation under Part E of EEOICPA bears the burden of proving by a preponderance of evidence that “toxic exposure was as least as likely as not a significant factor in contributing to, aggravating or causing a disease.”

SITE EXPOSURE MATRIX

Mr. Udall: Assistant Deputy Secretary, Mr. Shelby Hallmark, in a letter to the Alliance of Nuclear Worker Advocacy Groups, acknowledged that the Site Exposure Matrix is incomplete and that interested stakeholders may submit evidence of other toxins present at DOE facilities. If interested stakeholders do not know what is on the private SEM, how can they offer evidence that the SEM is incomplete or inaccurate? This same scenario can be applied to survivor claims. A survivor could assume that the worker was exposed to toxins that are still classified. Are there procedures in place that would ensure that living workers are afforded the opportunity to offer classified information to DEEOICP that may help prove their claim? What is the procedure for survivors who know their spouse may have been potentially exposed to classified toxins?

Ms. Chao: The version of SEM made available for viewing by the public on the Internet is a helpful guide for individuals concerned about exposures at their workplace. The website lists all toxic substances verified as potentially having been present at each covered facility. Claimants, the public, and other interested stakeholders are welcome to provide evidence and comments, and hundreds of substances have been added to SEM as a result of public input. While classified documents have yet to be received from claimants or other public sources, DOL has procedures in place to evaluate classified information.

A national security issue can arise because of the “mosaic effect,” whereby individually non-classified data points (e.g., types of chemicals, processes, and locations) if combined could provide a means of deducing highly sensitive information regarding nuclear weapons work. Given these national security

concerns, we were unable to provide buildings/areas and other process-specific information on the public Internet site. The information as it is arrayed for claim adjudication does amount to classified material and cannot be released in its present form. The current format and level of detail on the public website allows claimants to view exposure data at a given site without compromising national security issues.

EEOICPA PART E DEFINITION OF “TOXIC SUBSTANCE”

Mr. Udall: Does DEEOIC consider radiation exposure a toxin under Part E?

Ms. Chao: Yes, DEEOIC considers radiation exposure a toxin under Part E of the Act. Our Part E definition of a “toxic substance” is “any material that has the potential to cause illness or death because of its radioactive, chemical or biological nature.”

LIST OF DISEASES WITH NO CASUAL LINK TO TOXIC EXPOSURE

Mr. Udall: Final Bulletin Number 06-10 lists diseases that have no casual link to toxic exposure. How was this list developed and by whom? Was this list made available to an unbiased medical community for comments or input?

Ms. Chao: Bulletin 06-10 contains a list of diseases for which DOL has been unable to find medical evidence that would demonstrate a causal relation with any known toxic substance. The list was developed by the technical staff in DEEOIC. Because it is limited to providing claims examiners with guidance on how to expedite adjudication of claims for these diseases, as well as how to request and evaluate additional evidence, it was not sent for medical peer review.

PRESUMPTIVE DISEASE LISTS

Mr. Udall: Presumptive disease lists have been developed for uranium miners, millers and transporters as well as cancers deemed presumptive under the Special Exposure Cohort. Many toxins have been found to affect the same biological systems. What prevents DOL from developing a comprehensive presumptive disease list, where a claimant needs only prove he/she has the disease and the building at the facility had a corresponding toxin present?

Ms. Chao: Part B of EEOICPA specifies the circumstances under which uranium workers may be compensated. Under Part B, an individual who has received a \$100,000 award under Section 5 of the Radiation Exposure Compensation Act (RECA), is eligible to receive an additional lump sum compensation award in the amount of \$50,000 under Part B of the Act for the same illness. (RECA awards are administered by the Department of Justice.) Further, in order to receive benefits under Part B of the Act, a member of the

Special Exposure Cohort (SEC) must have been diagnosed with a “specified cancer.” Part B of the Act statutorily defines the term “specified cancer” to mean either (a) a specified disease as the term is defined under RECA; (b) bone cancer; (c) renal cancers; and (d) leukemia (other than chronic lymphocytic leukemia, if initial occupational exposure occurred before age 21 and onset occurred more than two years after initial occupational exposure).

Part E of the Act does not specify any disease for which a worker is presumed to be entitled to compensation. The statute does provide, however, that those illnesses accepted under Part B of the Act are also accepted under Part E of the Act. In all other cases where an illness has not previously been accepted under Part B, the Department of Labor (DOL) must determine whether it is “at least as likely as not” that exposure to a toxic substance at a covered Department of Energy facility was a significant factor in causing, contributing to, or aggravating the illness. DOL has provided guidance to its claims examiners regarding the likely causation relationships of certain diseases under Part E in its EEOICPA Bulletin 06-13, “Establishing causation for specific medical conditions under the EEOICPA,” issued on July 11, 2006. The specific medical conditions known to have a causal relationship with exposure to specific toxic substances include asbestosis, hemangiosarcoma/angiosarcoma of the liver, laryngeal cancer, leukemia, and mesothelioma. As new medical and scientific evidence becomes available establishing the levels of exposure and the onset of a given occupational illness, DOL will add to this listing, which expedites approval of cases involving these conditions.

FEDERAL LAWSUITS CHALLENGING DENIAL OF EEOICPA BENEFITS

Mr. Udall: How many federal lawsuits have been filed against your department for negative decisions made under both Part B and Part E of EEOICPA? To date, how much money has been expended by the federal government in defending these lawsuits?

Ms. Chao: There have been 17 federal lawsuits filed against the Department of Labor (either alone or in conjunction with the Department of Health and Human Services) for negative decisions made under either Part B or Part E of EEOICPA, none of which have resulted in a judgment overturning a Final Decision issued under EEOICPA. Since 2005 when the first lawsuit was filed challenging a denial of EEOICPA benefits, we have recorded approximately 4000 hours on these cases in the Office of the Solicitor. We do not have records reflecting time spent on these cases by other DOL staff or by the Department of Justice attorneys who represent DOL.

CUTS IN TRAINING AND EMPLOYMENT SERVICES

Mr. Honda: Sect. Chao, in the FY 2008 Omnibus appropriations negotiations and during last year's hearing, you and the President insisted on a rescission of \$335 million in "excess" state grant funds for youth, adult, and dislocated worker training programs under Title I of the Workforce Investment Act. This rescission has had a direct impact on my own district, forcing our award-winning North Valley Job Training Consortium to close its doors every Friday because they do not have the funding resources to offer services to Santa Clara residents five days a week.

How do you defend the President's request to cut the training and employment services administration by 14.4% from last year? What am I supposed to tell my constituents when their one-stop career centers and workforce investment boards can no longer help them?

Ms. Chao: Our budget request goes in tandem with the Administration's proposal for job training reform, which seeks to provide services in a more cost-effective way. This reform proposal would consolidate the Employment Service and WIA Adult, Dislocated Worker, and Youth funding streams into a single funding stream to be used for Career Advancement Accounts and employment services. In addition to replacing the current siloed system of separate training programs, it would reduce administrative and overhead costs, give individuals more control over training resources, and most importantly, significantly increase the number of individuals who receive job training. Approximately 200,000 individuals receive training through the workforce system each year. However, these reforms would increase the number of workers trained to over 600,000.

Overall, the 2009 Budget makes a substantial investment in job training. Government-wide, the 2009 Budget invests more than \$13 billion in training and employment programs. Including Pell Grants for students pursuing training at technical or community colleges brings this total to \$23 billion.

COMMUNITY-BASED JOB TRAINING GRANTS

Mr. Honda: I'm glad to see a requested increase in the Community-based job training programs, as these were identified as effective ways to integrate education into our job training programs by previous expert panels but in the context of the President's proposed elimination of the Education Department's Perkins career and technical education program it seems almost an insulting proposal.

Ms. Chao: The Department's request for \$125 million will allow the award of 70 to 75 new grants that will contribute to the training of an estimated 26,000 individuals in the skill and competency needs of local high-growth, high-demand industries found in regional economies across the nation. In addition to

providing direct training to individuals, these grants are expanding and enhancing community colleges' abilities to provide training in local high-growth, high demand industries through activities such as the development of training curricula with local industry, hiring qualified faculty, arranging on-the-job experiences with industry, and using up-to-date equipment.

It is worth noting that the Administration supports the important role community colleges play in helping individuals upgrade their skills. The 2009 Budget increases funding for community colleges over 2008, by significantly increasing funding for Pell Grants and other programs. Compared to 2001, the 2009 Budget would provide roughly a 75 percent increase in funding to community colleges and the students who attend them.

FARMWORKER HOUSING

Mr. Honda: For more than 50 years, the Bracero program, which ended in 1964, and the H-2A program (formerly H-2) have required employers to provide housing to workers, and to provide it at no cost to the workers. Your proposal is to end this requirement, by allowing employers to provide housing that is charged to workers and by providing a housing "voucher" instead of housing that is not clearly defined.

Isn't it true that there is a severe shortage of decent affordable housing for farmworkers in this country and that many farmworkers live in grossly substandard housing?

Ms. Chao: There is nothing in the Department's NPRM that alters the employer's statutory obligation to provide housing to H-2A workers at no cost to the worker. The Department also has not proposed that employers be permitted to charge workers for their housing.

In the February 13, 2008, Notice of Proposed Rulemaking, the Department proposed to allow employers to provide H-2A workers a housing voucher as an additional option for employers to meet their statutory required housing obligation. The Department proposed several safeguards to ensure that the voucher option could not be abused, and that H-2A workers always receive the housing to which they are legally entitled. First, the voucher method may not be used in an area where the Governor of the State has certified that there is inadequate housing available for farm workers in the area of intended employment. Second, the voucher is not transferable and is not redeemable for cash by the employee, but rather may only be redeemed for cash paid by the employer to a party providing appropriate housing. Third, the voucher may not be used to secure housing located outside a reasonable commuting distance from the place of employment. Finally, when workers "pool" the housing vouchers to secure housing (e.g., to secure a house instead of a motel room), such pooling may not result in a violation of the applicable safety and health standards.

The proposed voucher is one way an employer may meet his obligation to provide housing. However, if acceptable housing cannot be obtained using the voucher, the employer is not relieved of his or her obligation to provide housing that meets the applicable safety and health standards. In that case, the employer must either provide or secure housing for the H-2A workers.

The proposed voucher is but one way an employer may meet his statutory obligation to provide housing. Any housing secured through a voucher would have to meet all applicable housing standards. If acceptable housing cannot be obtained via the voucher, the employer is not relieved of his obligation to provide housing meeting all applicable safety and health standards. The Department asked for comments in the NPRM on the idea of providing a housing voucher option, an idea that was an outgrowth of the AgJOBS legislation, and asked for public comment on whether such a system should be available and how it should be structured.

Mr. Honda: The AgJOBS legislation permits the use of a meaningful housing allowance, not a voucher of zero dollar value, but only if the governor of the state certifies that adequate housing for migrant workers is available. You have turned that around and would permit the use of a voucher unless the governor certifies that housing is not available – why won't your policy lead to H-2A workers living in substandard conditions?

Ms. Chao: See response above. The Department believes our housing voucher proposal offers more protection to farmworkers than the AgJOBS housing allowance provision as the Department's proposal would ensure that workers are provided housing meeting applicable Federal, State or local safety and health standards.

DETERMINATION OF FARMWORKER WAGES

Mr. Honda: I see that you are proposing to use the BLS OES survey instead of the current Department of Agriculture to determine farm worker wages. As I understand it, the Department of Agriculture surveys farmers to determine what their workers are paid but the OES survey does not survey any farmers but instead only surveys labor contractors. If you are attempting to protect the wages of U.S. farmworkers why would you base the wage standard on a survey that does not study farmers but instead relies on farm labor contractors?

Ms. Chao: The OES survey data covers agricultural establishments accounting for the employment of all types of hired agricultural workers, and approximately one-third of the 1.2 million hired farm workers in the U.S., according to the USDA. The OES survey is conducted by the Bureau of Labor Statistics and is the preeminent U.S. government data collection instrument for wage information. The OES survey is accurate, produces statistically valid wage

rates, and has been successfully used for years by the Department of Labor in administering other temporary worker programs. The OES data represents actual wages paid to employees of businesses that provide agricultural labor services. In addition, OES wage data is categorized according to agricultural occupations that are routinely filled by H-2A workers. Because the OES data is gleaned from wages paid to employees who perform the same type of work as H-2A workers, it provides a good basis for an appropriate comparison of the wages an employer would be expected to pay a non-H-2A worker for a particular job at a comparable skill level and in a specific geographic locale.

The USDA survey, by contrast, does not gather data specifically on wages paid to farmworkers, but rather gathers aggregate data on the total amount of wages paid by employers for all types of hired agricultural work. The USDA data is then extrapolated and averaged across several agricultural occupations (including occupations not typically available for H-2A workers) to produce just one wage for all agricultural jobs in each of 18 geographic regions. Thus, the Department has determined that OES data, rather than USDA data, provides the best approximation of the wages that should appropriately be paid to H-2A workers.

In developing the proposal, the Department examined data from the Census Bureau's Current Population Survey (CPS), which includes agricultural workers from both farm and nonfarm establishments. The CPS, a monthly survey of 60,000 households, collects information on the employment and unemployment experience of workers in the U.S. Examining the CPS data confirmed that the OES data covering wages paid by nonfarm agricultural establishments provides an effective and appropriate proxy for the wages paid directly to workers by farm operators. Estimates based on CPS data for 2006 show little difference in the mean or median earnings of agricultural workers employed by farm establishments and those employed by nonfarm establishments (the establishments within the scope of OES).

Mr. Honda: Let me read you something from the Report of the Commission on Agricultural Workers by Commissioner Phil Martin who is a leading agricultural labor economist:

"Worker, farmer, and agency testimony as well as research suggest that FLCs [farm labor contractors] are practically a proxy for the employment of undocumented workers and the egregious or subtle violations of labor laws."

"The expansion of FLC [farm labor contractor] activities in the wake of IRCA has helped to lower wages and incomes in rural America."

If Professor Martin is right isn't the Department institutionalizing wage depression by relying on a survey of labor contractors to come up with its new wage standard?

Ms. Chao: OES data provides the most precise estimate available of the wages paid to similarly situated U.S. workers in each occupation, skill level, and geographic locale, as explained above. As explained above, H-2A wage rates that are tailored to the specific occupation, skill level, and geographic locale of job opening protect the wages and working conditions of U.S. workers.

The Department is aware that some FLCs have engaged in abusive employment practices in the past, and has proposed features in the new rule to curb those abuses. Specifically, the Department's proposal would require that FLCs must attest to, obtain, and maintain a surety bond, based on the number of workers employed, throughout the period the temporary labor certification is in effect, including any extensions thereof. The Department's Wage and Hour Division will have authority to make a claim against the surety bond to secure unpaid wages or other benefits due to workers under the labor certification.

STANDARD SETTING FOR COMBUSTIBLE DUST AND DIACETYL

Mr. Ryan: In FY 2007, we asked you to report to us regularly about your issuance of standards on pandemic flu and diacetyl, among other hazards. Since then, we have also seen yet another horrific explosion involving combustible dust, which has so far killed 12 workers in Georgia. However, we have still received no hard and fast commitment from OSHA for issuance of a new standard on diacetyl or pandemic flu, nor any hard and fast commitment to issue a standard to prevent dust explosions in the industries outside of grain dust where OSHA's standard has proven so effective. OSHA's refusal to issue a standard flies in the face of the specific recommendation for such a standard from the US Chemical Safety Board.

When is OSHA going to take immediate action to issue standards on these critical issues of worker health and safety, before dozens or more workers are killed or sickened?

Ms. Chao: OSHA has taken aggressive action over the past few years to address these important health and safety issues. Regarding diacetyl, OSHA announced its intent to engage in rulemaking for food flavorings containing diacetyl in the Fall 2007 Regulatory Agenda. To help focus its research efforts to support rulemaking, OSHA held stakeholder meetings to solicit issues and concerns from union and business representatives. OSHA expects to begin the SBREFA process in Spring 2008 and will expedite development of a proposed rule after receiving the recommendations from the SBREFA report. The report required by Public Law 110-161 that addresses this issue has been forwarded to the Committee.

OSHA was petitioned by a number of union groups to issue an ETS for pandemic influenza. However, after careful consideration, the agency denied the petition because it could not legally support an ETS for a hazard that does not technically exist at this point. Instead, OSHA believes that developing guidance, which can

be readily modified as we learn more about the potential for a pandemic, is the most appropriate and effective course of action at this time. Last year, OSHA published general guidance to employers for preparing for a pandemic, and a Safety and Health Bulletin containing more comprehensive guidance for health care employers. Currently, OSHA has been working with the Department of Health and Human Services (HHS) to develop *Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza*, which will provide employers with a methodology and recommendations for calculating workplace stockpiling needs for respirators and facemasks. The report required by Public Law 110-161 that addresses this issue has been forwarded to the Committee.

On combustible dust, OSHA is considering the recommendation of the Chemical Safety Board to develop a comprehensive standard, as well as a Petition for an ETS recently filed by two unions. While evaluating regulatory approaches, OSHA is also addressing the combustible dust hazards through a multi-faceted approach, including the strong enforcement of existing standards, outreach, training, the creation and dissemination of guidance and educational materials, and cooperative ventures with stakeholders.

OSHA REFERRALS FOR CRIMINAL PROSECUTION

Mr. Ryan: We understand that as of the end of 2007, 92% of the inspections in OSHA's Enhanced Enforcement Program (EEP) involved fatalities. This means that there were a total of over 2000 fatalities involving employers with extremely serious violations.

However, the Department of Labor only referred 12 cases to the Justice Department for criminal prosecution under the OSHA act in FY 2006. There were only 10 referred in both FY 2004 and FY 2005.

Why are so few of these horrendous cases treated by OSHA as criminal violations and referred to the Justice Department, and what do you plan to do to change this unacceptable situation?

Ms. Chao: OSHA consults closely with the U.S. Attorney's office in making determinations of the necessity or likely success of a criminal referral. OSHA has referred 64 cases to the Department of Justice since 2001, more than any previous Administration in the agency's history. It is the Department of Labor's policy to evaluate all OSHA violations that contribute to workplace fatalities for potential referral to the Department of Justice for prosecution. However, criminal prosecution for violations of OSHA standards that cause the death of an employee is appropriate only for willful violations. OSHA conducts thorough evaluations of each violation, and in many cases has determined that fatalities are not the result of a willful violation of an OSHA standard. In some instances, OSHA found that workplace fatalities were the result of willful

violations, but was unable to provide the necessary quantity and quality of evidence for a successful criminal referral.

ACCEPTABLE LEVEL OF CARRYOVER FUNDS

Mr. Walsh: In FY 2008, the House included a rescission in the WIA accounts of \$335 million, which was upheld in Conference at \$250 million. At last year's hearing, it was confirmed that there is routinely somewhere between \$1.1 and \$1.7 billion that is "basically rolled over" from year to year and that "all the states have excess balances, as well". Several Members have asked this question, but we have yet to receive a straight answer. In your opinion, what is an acceptable level of carry over? Can you explain to the Committee the Department's apparent need to carry over balances?

Ms. Chao: The Workforce Investment Act of 1998 (WIA) allows states three years to spend WIA funds. However, we do not believe that Congress intended to allow funds to remain unused and accumulate over a three-year period. While there is a provision in current law for reallocation of funds based on obligations, it has been relatively ineffective in encouraging timely spending, as is evidenced by the amount of carryover you cite. While some carryover is necessary to continue operations, the large amount means that in many states and communities, large numbers of individuals in need of training are not receiving it while available funds remain unused.

We believe that a reasonable amount of unexpended funds that can be carried over from any program year to the next is not more than 30 percent. Therefore, the Administration's WIA reauthorization proposal provides that states with more than 30 percent of available funds unexpended at the end of any program year would be subject to recapture of funds and the amount recaptured would be distributed to other states.

MIGRANT AND SEASONAL FARMWORKERS

Mr. Walsh: Madam Secretary, last year, the distinguished former Chairman of this Subcommittee and I both spoke to you about the Migrant and Seasonal Farmworkers Jobs Program—a program that serves over 18,000 participants each year, providing assistance to those that are unable to access One-Stop Career Centers. Yet, for the 7th consecutive year, the Administration has proposed to terminate this program. It is said that the Department's integration strategy would incorporate these workers. Can you describe in detail the specifics of this plan? If there is a genuine belief that a more fully integrated workforce investment system can, indeed, provide adequate services to these workers, why not work with the Committee to establish a plan that would address our concerns?

Ms. Chao: Historically, two-thirds of National Farmworker Jobs Program (NFJP) participants receive only supportive services. The program is not

effectively providing the employment and training needs of farmworkers. Rather than placing farmworkers into a program that does not help most participants improve their skills and find stable, year-round employment, the Department believes that these workers should have access to the full spectrum of workforce investment services available through the broader workforce system.

The One-Stop Career Center system can provide a full array of employment and training services, as well as supportive services and other related assistance, available from 17 federal programs. Those being served by the NFJP have similar types of barriers to full-time employment that other workers do, and the relatively small NFJP does not provide its participants with the full array of benefits they would derive from the workforce investment system. Under the Department's FY 2009 proposal, ETA will undertake rigorous outreach programs targeted to farmworkers to increase awareness of services available through the One-Stop system and continue to provide technical assistance to support integration. This approach has been effectively utilized by other integrated Workforce Investment Act (WIA) programs serving workers with similar barriers to employment.

Additionally, ETA has already implemented a strategy within the current NFJP and WIA programs to integrate farmworker services into the broader workforce system in a variety of ways. Since WIA requires ETA to conduct a biennial grants competition for the NFJP, the last three Solicitations for Grant Applications have required applicants to design their program around program priorities designed to continue the drive towards the full integration of services. These priorities include expanding the network of employers using the system; targeting occupations in high-growth industries; and making operational the integration of services. In addition, the three Agricultural Business and Workforce System Integration Forums conducted in PY 2005 engaged agricultural employers and key leaders of the workforce system at the state and local levels in a discussion about workforce solutions to broaden the base of service providers competent to meet the needs of farmworkers.

HIGH GROWTH JOB TRAINING INITIATIVE

Mr. Walsh: The Congressional Research Service has reported that 90 percent of the grants for the Department of Labor's High Growth Job Training Initiative were awarded on a sole-source basis. Please explain your criteria for awarding these grants.

Ms. Chao: At its heart, the High Growth Job Training Initiative (HGJTI) represents a systemic change from the approach taken by the Department's Employment and Training Administration (ETA) in the past. With this new initiative, ETA felt that worker and employer needs would be served most quickly and effectively by awarding the initial HGJTI grants on a non-competitive basis. Given the Subcommittee's ongoing concerns about this issue, I first want to

assure you that these awards were merit-based and consistent with the statutory and DOL policy requirements governing non-competitive awards.

As preparation for making these awards, ETA took a rigorous approach to identifying growth industries, collecting data from industry leaders, and reviewing the large number of unsolicited grant applications. The HGJTI began with a tiered approach that included several key steps prior to making any financial investments. Each phase built on the next, offering a systematic approach to developing solutions to workforce challenges defined by business and industry:

- The first phase was to identify high growth, high demand industries. The HGJTI was designed to model how state and local partners could become more demand-driven by identifying the high growth, high-demand industries in their economies.
- The second phase was to conduct Industry Scans. Before reaching out to industry leaders and stakeholders, ETA completed a scan of the size, trends and scope of each industry as well as any previously identified workforce challenges in order to prepare better for dialogues on the industries' workforce needs and challenges.
- Third, ETA conducted Industry Executive Forums. With a better understanding of the context in which industries were managing their workforces, this phase of the process involved convening industry executives at the CEO level, often with the help of industry trade associations, to hear about the growth potential of their industries and to understand workforce challenges critical to continued growth. During this phase, ETA conducted 37 Industry Executive Forums with industry leaders across each of the industry sectors, reaching 815 industry partners through the process.
- Fourth, ETA held a series of Workforce Solutions Forums. These forums again brought together high-level executives, often those engaged in companies' human resources and training activities; labor representatives, where appropriate; representatives from the continuum of education; and the public workforce investment system. Many of the organizations and individuals who participated were already engaged in the process of identifying workforce solutions for the industry. The primary outcome from these forums was a set of industry-driven solutions for each industry, which was compiled and published in an overall industry summary report. In total, ETA conducted 15 Workforce Solutions Forums, reaching 627 strategic partners.

One of the outcomes of this approach was that ETA received over 450 unsolicited grant proposals. Many of these proposals put forth a truly innovative approach to workforce solutions, and many of the applicants demonstrated a commitment to

their approach by proposing to provide substantial funding or other contributions to the project.

Given the large number of excellent proposals received, ETA concluded that initial investments in workforce solutions to address industry identified challenges could and should be made without a formal "Solicitation for Grant Applications." It was, however, ETA's intent from the early phases of the HGJTI to move to a fully competitive investment model, and the unsolicited proposals were reviewed in much the same way as competitive proposals are reviewed. ETA reviewed the proposals received with an intent to fund those proposals that: 1) were innovative; 2) responded directly to the issue areas defined by industry; 3) represented strategic partnerships that included business and industry, education, and the public workforce investment system; and 4) in many cases, leveraged both public and private funding from other sources.

Grants under the HGJTI have been awarded to a wide range of organizations as follows:

- 45 to public workforce investment system organizations, including Workforce Investment Boards, One-Stop Career Centers, and state/local workforce agencies;
- 36 to employers, industry associations and labor/management organizations (two were awarded directly to unions and five to grantees that have unions as partners);
- 48 to community colleges and educational institutions representing the continuum of education; and
- 21 to community-based organizations.

In awarding these particular grants, ETA complied with Workforce Investment Act requirements for non-competitive awards, and also ensured that awards were made consistent with internal DOL standards that apply to non-competitive awards. This included, when required by DOL's policies, submitting proposed non-competitive grants to the Office of the Assistant Secretary for Administration and Management/Chief Acquisition Officer for review by the Department's Procurement Review Board and the Office of the Assistant Secretary for Administration and Management/Chief Acquisition Officer.

From the outset, ETA intended to move to competitive HGJTI awards after the first round of grants in each industry sector, and ETA began that process in Program Year 2004. Currently, all High Growth Job Training grants are awarded through a competitive process.

HEALTHCARE WORKERS AND PANDEMIC FLU

Mr. Walsh: I understand the Department has not issued an emergency temporary standard (ETS) to protect healthcare workers in the event of an

influenza pandemic because of the “grave danger” requirement in the Occupational Safety and Health Act. If this is the case, please explain the steps the Department is taking to address the emerging threat of a pandemic flu. Please provide any suggested legislative changes the Congress could pursue that would pave the way for the Department to issue an ETS. Finally, what are the reasons the Department has not pursued a new permanent rule to protect healthcare workers in the event of an influenza pandemic?

Ms. Chao: After careful consideration, OSHA decided against issuing an Emergency Temporary Standard for pandemic influenza because we can not legally support an ETS for a hazard that does not technically exist at this time. OSHA believes that developing guidance, which can be readily modified as we learn more about the potential for a pandemic, is the most appropriate and effective course of action at this time. Last year, OSHA published general guidance to employers for preparing for a pandemic, and a Safety and Health Bulletin containing more comprehensive guidance for health care employers. Currently, OSHA is working with the Department of Health and Human Services (HHS) to develop *Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza*, which will provide employers with a methodology and recommendations for calculating workplace stockpiling needs for respirators and facemasks. The report required by Public Law 110-161 that addresses this issue has been forwarded to the Committee.

STAFFING REQUEST FOR ESA’S WAGE AND HOUR DIVISION

Mr. Walsh: How does the Employment Standards Administration plan to utilize its Wage and Hour Division Full-Time Equivalents (FTE) if the Congress approves the Fiscal Year 2009 Budget request for an additional 75 FTEs?

Ms. Chao: In FY 2009, WHD will continue its efforts to ensure that the nation’s immigrant worker population is employed in compliance with wage and hour laws, and that immigrants who establish new businesses are familiar with WHD’s worker protection statutes. As an adjunct to its compliance priorities in low-wage industries, WHD will focus on addressing changes in employment relationships, especially those involving a contingent workforce, misclassified employees, or evolving subcontracting structures. The requested resources would enable WHD to employ additional front-line staff to ensure it has sufficient resources in the Gulf Coast and throughout the country to offer an effective balance between its directed enforcement program in low-wage industries, including child labor and agriculture, and its complaint-driven enforcement program. Dedicating more enforcement resources to low-wage industries would increase WHD’s directed enforcement program. WHD would also preserve its current practice of resolving complaint investigations in a timely and efficient manner and promoting future compliance among employers.

STAFFING REQUEST FOR ESA'S OFFICE OF LABOR MANAGEMENT STANDARDS

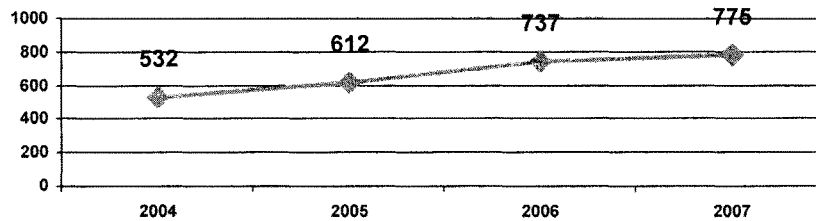
Mr. Walsh: How does the Employment Standards Administration plan to utilize its Office of Labor Management Standards if the Congress approves the Fiscal Year 2009 Budget request for 369 FTEs?

Ms. Chao: The Office of Labor-Management Standards (OLMS) ensures safeguards for union democracy and financial integrity and union transparency under the Labor-Management Reporting and Disclosure Act of 1959, as amended (LMRDA), and related laws. The LMRDA establishes standards of conduct for unions and requires reporting by unions and others for public disclosure access. OLMS also certifies fair and equitable protective arrangements for transit employees when Federal funds are used to acquire, improve, or operate a transit system. Resources at the FY 2009 request level, \$58,256,000 and 369 FTE, would allow OLMS to continue core program work in support of the LMRDA

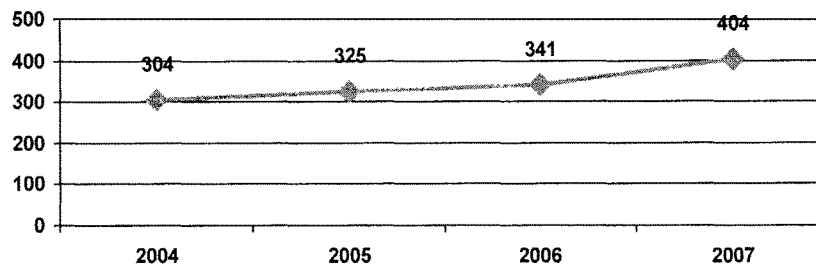
OLMS' request for \$11.950 million and 52 FTE will enable the agency to undertake more investigations, conduct more audits, provide additional compliance assistance, and ensure greater compliance with statutory reporting requirements. The additional investigators will result in an additional 120 criminal investigations, 150 criminal audits, 150 civil investigations in cases involving reporting of conflicts-of-interest transactions, and 100 additional compliance assistance sessions.

With the 369 FTE, OLMS would continue all mandatory LMRDA program work in support of the goal to protect union democracy, principally union officer election reruns as required under the law. OLMS would also continue to administer its LMRDA reporting and disclosure program, including operation of the electronic report filing and Internet Public Disclosure System. OLMS also would continue a strong program of union audits and criminal investigations to support LMRDA union financial integrity protections. Absent resources at the FY 2009 request level, OLMS could not sustain its current union financial integrity program. This would result in a decrease in the number and quality of audits and a resulting decrease in Department's ability to uncover and deter embezzlement. Absent the requested resources, this deterrent would be weakened and union member dues would go unprotected.

In recent years (with the notable exception of fiscal year 2008), OLMS has received increased resources, primarily to strengthen the LMRDA union financial integrity program. With these resources, OLMS has been able to significantly increase the number of union audits conducted, which has allowed the agency to extend LMRDA financial integrity protections to a greater number of unions and union members. The following chart shows the number of union compliance audits (CAPs) conducted over the past few years.

Union Audits Conducted

The increase in resources also has contributed to an increase in the number of union funds embezzlement investigations conducted to protect union members' dues and union financial integrity. Following investigation, OLMS refers findings of criminal violations to the Department of Justice for prosecution. Criminal prosecution of embezzlement frequently results in restitution. The following chart show the increase in criminal investigations conducted in recent years.

Criminal Cases Processed

With the resources requested in the President's 2009 Budget, OLMS would be able to maintain core program work to support LMRDA union financial integrity and adequately protect union members' dues.

WEDNESDAY, FEBRUARY 27, 2008.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUDGET FOR 2009**

WITNESS

HON. MICHAEL O. LEAVITT, SECRETARY

Mr. OBEY. Well, good morning, everyone.

Mr. Secretary, as I said several times before this year, this Subcommittee has jurisdiction over a lot of programs, many of which are aimed at helping people who start out in life a little behind the starting line or even a lot behind the starting line, and they are also meant to help a lot of people who fall out of the race along the way, to get them back on track.

Before Franklin Roosevelt, the government pretty much let people alone, and they were on their own. With Roosevelt and the New Deal, we began to build a series of initiatives that tried to make quite clear this was a caring society.

When Dwight Eisenhower took over, as the quote behind me notes, Eisenhower decided not to try to repeal those initiatives, and so we have sort of had a bipartisan consensus for years on the obligation of the government to do more than stand by and view with alarm when people are getting tossed around on the wild seas of life.

Last week, this Subcommittee held several overview hearings to talk about the context in which these decisions are being made, and we had another hearing yesterday on that subject.

Example: Between 2004 and 2005 alone, real after tax income jumped by an average of 180,000 bucks for the top 1 percent of households but increased by only about \$200 for low income households. That, I think, paints a clear picture that we are continuing to have what has been a two decade long or more widening of the gap between the most well off in this society and many, many others.

Some of these programs are meant to try to help narrow that gap, and others are simply meant to deal with the consequences of that gap. We have often talked about, well, we talk every year about the cost of doing certain things, the cost of adding money for NIH or the cost of adding funding for student aid and the like, but we do not focus, in my view, enough on the cost of not doing those things. So we have been trying to cover both sides.

I am very concerned about what this budget does, given the context in which it is being presented because the budget that you are presenting today freezes funding for biomedical science, it spends \$475 million less than last year on critical public health promotion and disease prevention programs, cuts funding for health care quality outcomes and effectiveness research below last year's level,

and in real dollar terms those cuts are even more severe than they appear.

I appreciate the \$27 million increase for community health centers, but that increase is less than the rate of inflation and does not go very far to help the 40 million plus people who do not have health insurance.

The proposal to terminate health professions training programs, I think you will find that there are people on both sides of the aisle in this Committee who have considerable doubts about the wisdom of that.

And so, basically, at the least I am concerned about the inadequacy of a number of recommendations, certainly not just in your Department. We had a good deal of discussion yesterday on education about the failure of Congress over a good period of time and the failure of Presidents of both parties to adequately fund Special Education, for instance.

I just want to make one comment before we begin. Last year was very frustrating, and I said the same thing to the Education Secretary yesterday. Last year was very frustrating to me because I am used to the kind of politics in which you have the two parties. When issues divide on partisan lines, I am used to the kind of politics in which people define their differences and fight like hell about them but then resolve them, and usually that resolution means that you have to have compromise on both sides.

We did not get much of that compromise from the Administration last year. In fact, Mr. Nussle specifically warned me that we would not find anyone in the Administration interested in compromising on last year's budget, and that certainly proved to be an accurate description.

This year, we face a little different situation because, as you know, this is the last budget that this Administration will present, and we will have two choices. We can either allow this year to turn into a wasted eight months where we go through the motions of debating each other about your priorities and ours and, in the end, get nowhere in terms of a compromise or we can recognize that we have different philosophies but also recognize for the good of the order we need to cut to the chase and make those compromises and get a move on.

I would much prefer to do that than to reach an impasse, but it is really pretty much up to the Administration to decide how they want this to go. I am perfectly willing to sit down and compromise on virtually any item in this bill, but if we get clear signals from the Administration that that is not the path they want to go on, then we have no choice but to simply wait and deal with the incoming President who we expect will be flexible.

So I would simply ask you for whatever it is worth, and I know that these decisions are made by OMB a lot more than they are made by the agencies, but in the end you are a lot closer to the needs of these programs and the people who are served by them than OMB is.

So, for whatever it is worth, I hope that you and the Secretary of Education and the Secretary of Labor will take back the message that it would be good if we could work things out because if we do not, then the Administration will simply be a bystander and we

will have to make these decisions with benefit of input from whom-ever succeeds the President.

As I say, I prefer to work it out, but I will play it flat or play it round, however the Administration wants to go with it.

So, with that, let me turn to Mr. Walsh and see what comments he has before we hear your testimony.

Mr. WALSH. Thank you, Mr. Chairman. Thank you for holding this hearing today.

Mr. Secretary, welcome. Nice to see you.

The Committee, the Appropriations Committee has responsibility for spending, discretionary spending. Most of this Subcommittee's jurisdiction is mandatory spending which we have very little control over, but those mandatory programs are putting a tremendous burden on our ability to meet the needs of the Country through discretionary means.

I am not sure how that is resolved, but the growth that is occurring in mandatory programs at the same time we have had a tremendous buildup in our defense spending is really squeezing non-defense discretionary spending. All across the responsibilities of the Appropriations Committee—infrastructure, education, health care research and other areas that are of great concern to the American public—are being squeezed by both defense spending and entitlement programs.

Both of those areas, I am sure, are going to be very closely looked this year and in the next Congress. So I would be interested in hearing any thoughts you have on entitlement spending which comes within your purview.

Just a thought, the Medicaid program, as it was established, requires that States pay a portion of those costs. Certain States, southern States primarily, benefit substantially from the Federal largess. The Federal Government spends a much higher proportion of the Medicaid bill in Alabama, Mississippi, Tennessee and other southern States whereas some of the other States like mine, New York, we pay dollar for dollar what the Federal government pays.

In New York, that dollar comes 50 percent from the State Government and 50 percent from county government. So there is a tremendous burden put on the local taxpayers to pay for a program, the Medicaid program, for which they have no control.

I understand part of your approach is to shift costs from the Federal Government to the State. In my State, that creates a tremendous and onerous burden on county property taxpayers who have enough problems of their own. So it is a real cause for concern, this shifting of costs from the Federal Government to State and then to local, and I would like to explore that with you a little bit in the Q&A.

Again, thank you.

Thank you, Mr. Chairman. I yield back.

Mr. OBEY. Why don't you proceed? We will put your statement in the record. Why don't you summarize it, and we will get to the questions?

SECRETARY'S STATEMENT

Secretary LEAVITT. All right. I do not think I will follow my prepared statement. If you will submit it in the record, I will feel good about that.

Mr. Chairman, let me just say I have been in the budget business a long time, as have you. Most of my experience came in a much smaller pond. As you know, I was a governor for 11 years, and it was my duty to be the voice and to make all of the decisions.

I am now in a much different role. I have a substantially larger budget and a much bigger pond, but my role is a little different.

I want to express that in the context that I understand your statement and understand the spirit with which it is given. The Administration feels very strongly about the need to balance the budget by 2012, and I think it is a voice that has to be represented in this discussion.

There is a need for the voice of the Hubert Humphrey quote behind you. I think there is no one in this room who does not understand that and believe that. I do. I take that responsibility very carefully. I also feel the need to keep the discipline that is necessary to keep government in the right place.

So you will see in this budget an effort to balance the budget and to maintain the sustainability of the programs that so many people depend on.

I will tell you I am deeply worried about Medicare. This budget contains \$183,000,000,000 in reductions in the growth rate. It reduces it from 7.2 to 5 percent growth. I do not relish in bringing the list of things that would accomplish that. I know the realities of it.

I bring it as a warning, not to you—you know it—but to state it publicly and resoundingly that we have to do something about this. Whether it is this year or another year, someone is going to have to deal with this.

My testimony represents a view that simply dealing with it by using the same old Government-regulated price-setting mechanism is going to be so uncomfortable, it is likely it will never be done, and the better way is to change the philosophy of the system and begin to see it rationalize itself in a way that I believe makes more sense. I will not go into a lot of detail.

I am anxious to have the conversation about Medicaid. I ran Medicaid programs for many years as a governor. I have now overseen them as the Secretary of Health and Human Services. I have great respect for the partnership that exists between the States and the Federal Government.

I recognize some inequities that have historically been built into it. In the recent months, we have proposed a series of changes to Medicaid that, frankly, represents disputes in the partnership between States and the Federal Government.

To be honest, and I understand this mentality as well as anybody in the room, States have hired consultants who, on a contingency fee basis, have found ways to go in and find any hint, any whiff of ambiguity and then have driven a wedge in there on a contingency fee basis where they have absolutely no incentive to do anything but push and push and push and push and push.

Well, somebody needs to push back because many of the things that are being done here are simply not fair. They are not in the spirit of what is being done, and yet they are represented to be some kind of pushing things off onto the States when in reality we are trying to find the balance in this partnership. So I hope we do get a chance to talk about that.

My job is to try to find the right place and right now, absent the capacity to push back a little bit on what is being done, we are being taken advantage of. That means that there is money going to one thing that really ought to be going to another.

So, Mr. Chairman, I am prepared to have this conversation in a very thoughtful way. I appreciate the spirit in which you have addressed it, and I hope to do the same.

[The information follows:]



TESTIMONY
BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
UNITED STATES HOUSE OF REPRESENTATIVES

STATEMENT BY

THE HONORABLE MICHAEL O. LEAVITT

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

For Release on
Wednesday, February 27, 2008
at 10:00 AM

**Statement of Michael O. Leavitt
Secretary, U.S. Department of Health and Human Services
FY 2009 Budget Request for the
Department of Health & Human Services
Wednesday, February 27, 2008**

Chairman Obey, Congressman Walsh, and Members of the Committee, thank you for the invitation to discuss the President's FY 2009 budget request for the Department of Health and Human Services (HHS).

Throughout the entirety of this Administration's two terms, the President has sought to increase access to affordable health care, protect our nation against public health threats, advance medical research, and serve the needs of our most vulnerable citizens. The President has tried to meet these challenges while balancing his obligation for fiscal responsibility.

To support these ongoing goals, the President proposes total outlays of \$737 billion for Health and Human Services. That is an increase of \$29 billion from 2008. Our proposed FY 2009 discretionary budget totals \$68.5 billion. Within this total, our request for discretionary budget authority for programs under the jurisdiction of this Subcommittee is \$63.2 billion.

The most important story in the Department's budget is the need for entitlement reform and our proposed changes to Medicare and other mandatory programs. However, I recognize this hearing is focused on discretionary aspects of the HHS budget so I will start by discussing programs under the direct purview of this Subcommittee before returning to mandatory programs later in my statement.

Setting Priorities

Overall, our discretionary budget proposes \$2.2 billion in net savings from last year. Much of that difference comes from a repeat of programs that we have previously recommended for reduction or elimination. We have identified underperforming, inefficient or duplicative programs and redirected our resources to programs that provide a greater benefit for our tax dollars. I understand we will disagree over funding levels for some programs but it is important to recognize that budgets are about choices and priorities.

In that context, I would like to spend a few minutes discussing our priorities in this year's discretionary budget.

Emergency Preparedness

Our nation remains at risk of terrorist attack and war. HHS is responsible to prevent and detect attacks, and respond to mass casualty events. Our budget proposes \$4.3 billion to:

- Increase bioterrorism readiness
- Double advanced development of medical countermeasures
- Establish new international quarantine stations
- Expand and train medical emergency teams

We are seeking \$507 million to continue funding the President's pandemic influenza preparedness plan.

One part of our preparedness budget that I would like to highlight for you deals with ventilators. In many emergencies, especially terrorist attacks or pandemics, ventilators are needed to help victims breathe. Currently, ventilators cost \$8,000 to \$10,000 each. They also require specially trained teams to operate them. The combination of those two factors makes having an adequate supply nearly impossible.

We are requesting \$25 million to develop the next generation of ventilators that are portable, up to 90 percent less expensive and do not require special training to operate.

Global Health

You will see a series of health diplomacy initiatives. Because threats to human health have become just as mobile as we are, our leadership in health around the world benefits Americans directly.

In addition to our work on HIV/AIDS, Malaria and Tuberculosis, I am asking for \$3.5 million to provide public health services and training in developing countries.

Biomedical Research

We have proposed increases for each Institute and Center at NIH. The overall budget will support 38,000 research project grants, including more than 9,700 new and competing awards. Overall, the NIH budget will be the same as FY 2008.

Head Start

This budget proposes \$7 billion for Head Start, an increase of \$149 million over last year. The increase in funding will be used to provide programs a cost-of-living increase of 1.9 percent, enabling them to continue serving approximately 895,000 children, the same level as in FY 2008, with comprehensive child-development services to help them arrive at school ready to learn.

Health Care Fraud and Abuse (HCFAC)

We are also seeking \$198 million in new HCFAC discretionary funds to help fight fraud and abuse. These funds will be used by CMS, the Inspector General, and Department of Justice to fight fraud and abuse in the new Medicare prescription drug benefit and

Medicare Advantage programs, and strengthen financial management oversight of the Medicaid program.

Disaster Human Services Case Management

Our budget includes \$10 million to develop a new Disaster Human Services Case Management program. The impact of a disaster on an individual's or a family's well-being is often far more profound than any physical damage a disaster might bring. This program will build the capacity to tie together existing organizations with expertise in case management and recruit, train and credential volunteers across our nation to come to the aid of those who have been affected by disasters and help them connect with public and private support to begin rebuilding their lives.

Health IT

Our budget includes \$66 million for the Office of the National Coordinator for Health IT. This funding supports policies to encourage physicians and others to adopt electronic health records (EHRs) and supports technologies for safe, secure health information exchange.

Physician adoption of EHRs can improve the delivery of health care by reducing medical errors and increasing efficiency. To further the adoption of health IT, \$3.8 million is included in the FY 2009 CMS budget for a demonstration project involving up to 1,200 physician practices to improve quality by increasing the functionality of their EHR systems.

Health Centers

We are seeking an additional \$27 million to build on the success of the President's Health Center Initiative. In FY 2008, the Health Center Program surpassed the President's goal of creating 1,200 new or expanded Health Center sites across the nation. In FY 2009, the budget will fund 40 new access point grants in high poverty areas without access to a Health Center, along with 25 planning grants – expanding service to more than 17 million total clients.

Commissioned Corps

The Budget includes \$30 million to increase training, equipment, and emergency response and operational capacities for the Commissioned Corps. This request will support a wide variety of activities, including the staffing and equipping of two Health and Medical Response teams of 105 members each.

SAMHSA Treatment Courts

Our budget includes \$40 million for behavioral health and recovery support services associated with treatment courts, an increase of \$30 million over FY 2008. Treatment courts use incentives, sanctions, and close supervision to ensure that offenders experiencing mental health or substance use disorders continue with their treatment plans and break the cycle of abuse and incarceration.

Mandatory Spending

Now I would like to turn to Medicare, Medicaid and SCHIP.

To put it bluntly, the Medicare portion of this budget should be viewed as a stark warning. Medicare, on its current course, is not sustainable. In 2007, the Medicare Trustees reported the Hospital Insurance Trust Fund will be exhausted in 2019 – 11 years from now – and Medicare represents a \$34.2 trillion unfunded obligation for the federal budget over 75 years. This is a serious matter.

Let's acknowledge that American sensitivity to entitlement warnings has become numbed by a repeated cycle of alarms and inaction. Such warnings have become a seasonal occurrence, like the cherry blossoms blooming in April, part of life's natural rhythm. We hear the warning, but do nothing.

This budget warns in a different way. It illuminates with specificity the hard decisions policy makers – no matter what their party – will face every year until we change the underlying philosophy. The President believes we can keep our national commitment to insuring the health of Medicare beneficiaries, but we need a change in how we manage the system.

Currently, the Medicare fee-for-service program is a centrally-planned, government regulated system of price setting. Price setting systems allow government regulators to decide the priorities. Government decides which treatment to cover. Government decides how much treatment is provided based on how much government is willing to pay for. Government tries to determine how much value different procedures have. It is a bad system and needs to be changed.

If consumers were allowed to make these decisions through an efficient and transparent market, their decisions would be far more precise and wise.

One need look no further than our experience with Medicare's prescription drug benefit, where government organized a market and let consumers decide what drug plan worked best for them. Entering the third year of the program, we see enrollment continuing to rise, beneficiary satisfaction extremely high, and costs to beneficiaries and taxpayers considerably lower than originally projected.

A month ago we announced that, compared to original Medicare Modernization Act (MMA) projections, the projected net Medicare cost of the drug benefit is \$243.7 billion lower over the 10-year period (2004-2013) used to score the MMA. Beneficiaries are saving as well. The most recent CMS estimate of the actual average premium beneficiaries will pay for standard Part D coverage in 2008 is roughly \$25. This is nearly 40 percent lower than originally projected when the benefit was established in 2003.

While there are several important factors that contribute to lower costs, a key factor is that competition has been strong from the beginning of the program and the plans have achieved greater than expected savings from retail price negotiations, manufacturer rebates, and utilization management.

That said, however, using the blunt instruments we have available to us in other parts of Medicare, we have prepared a budget with three goals in mind: long term sustainability, affordable premiums for beneficiaries and a balanced national budget by 2012.

Some will be unhappy with this budget. While Medicare spending will increase by an average of 5 percent annually under our budget, they will see any attempt to slow the rate of Medicare's growth as a cut.

Our proposed budget includes a group of legislative and administrative improvements aimed at extending Medicare's viability for today's seniors and future generations. The slower growth rate they produce saves \$183 billion over five years.

The proposals include:

- Encouraging provider competition and efficiency
- Promoting high quality care
- Rationalizing payment policies
- Improving program integrity
- Increasing high-income beneficiary responsibility for health care costs

The slower growth rate also reduces the premiums beneficiaries face by \$6.2 billion over the next five years. Let me emphasize that generally, changes we make that reduce future government spending also give a financial break to beneficiaries.

I mentioned Medicare warnings earlier. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress included a provision requiring the Medicare Trustees to issue a formal warning if two consecutive annual reports show that regular tax dollars exceed 45 percent of total Medicare spending within the current or next six years. I am a Trustee of the Medicare Trust Fund. Last year we triggered the alarm. As usual, there has been no action.

The same law calls for the President to propose legislation that will change the trajectory enough to bring general revenues back below 45 percent. The President believes it is important to respond to the 2007 warning about the future fiscal health of Medicare.

I was designated by the President as the official responsible for this response and on Friday, February 15, I submitted legislation to Congress.

This legislative package addresses the immediate problem identified by the 2007 warning and helps lay the foundation for transforming Medicare so it becomes a program based on the highest quality and the greatest value. This proposal should be enacted in conjunction with the Medicare savings in the 2009 budget, which addresses nearly one-third of the program's \$34 trillion unfunded obligation.

The legislation we propose offers a three-step approach to the problem of unsustainable Medicare spending growth.

Title I provides the HHS Secretary with the authority and responsibility to introduce value-driven competition into the Medicare program. These principles are intended to reduce Medicare spending by increasing provider efficiency and helping beneficiaries to be wiser consumers. Specific elements in the legislation include:

- Adoption of health information technology, such as electronic medical records and e-prescribing;
- Transparent pricing information;
- Transparent quality information; and
- Incentives for providers to deliver and beneficiaries to choose high-quality, low-cost health care.

Title II of this legislation implements the President's medical liability reform agenda.

- The medical liability crisis has littered our courts with junk lawsuits. It has hindered patient care, resulting in 1500 counties lacking an Ob-Gyn. And it costs our health care system up to \$100 billion per year.
- We need reform in order to have a rational medical liability system.

Finally, Title III reduces the Medicare premium subsidy for higher-income individuals in Part D.

- Income-relating the Part D premium was contained in the President's last two budget proposals.
- It will save over \$900 million in 2013 and nearly \$3.2 billion over five years.

Although this package responds to the funding warning identified in the 2007 report, more must be done to strengthen Medicare for the long-term.

I am eager to work with Congress to quickly pass this legislation – and the savings proposed in the President's Budget – so we can get started on making Medicare a healthy program for current and future generations. But real solutions in Medicare will require genuine change in the way in which health care is conducted in America. And, if I can comment on that broader topic for a moment, let me say this:

There are two competing philosophies about the role government should play in health care. One is a Washington-run, government-owned plan, where government makes the choices, sets the prices, and then taxes people to pay the bill.

The other, supported by the Administration, is a private market where consumers choose, where insurance plans compete, and where innovation drives the quality of health care up and may drive the cost down.

The Administration believes every American needs access to health care at an affordable cost. In addition to its proposed tax reforms and health insurance market-based initiatives, the Administration believes the current health care system could operate more efficiently, without increasing federal spending on health care, if some portion of indirect public subsidies were redirected to make health insurance affordable for individuals with poor health or limited incomes. The federal government would maintain its commitment to the neediest and most vulnerable populations, while giving the States, which are best situated to craft innovative solutions, the opportunity to move people into affordable insurance.

We are approaching an emergency. Real change in Medicare as a system is required, and soon. If you are 54 years old, and if Medicare is left on autopilot, when you turn 65 years old, Medicare will not be able to provide all the hospital insurance benefits promised under current law. We need a change in philosophy – not just a change in the budget.

State Children's Health Insurance Program (SCHIP)

The President proposes to increase funding to states by \$19.7 billion through 2013, with \$450 million in outreach grants. Our proposal is consistent with the Administration's philosophy that SCHIP should focus on its intended target – uninsured, low-income children – instead of expanding to other segments of the population. It is also consistent with the position the President and the Administration articulated last fall. Our legislative proposal calls on Congress to address the issue of "crowd-out." It outlines State responsibilities when they expand SCHIP, proposes enforcement mechanisms, and clarifies SCHIP eligibility by clearly defining income.

Medicaid

We are continuing our successful transformation of the Medicaid program. This budget request includes a series of proposed legislative and administrative changes. We propose legislative savings of more than \$17 billion and assume administrative savings of approximately \$800 million over the next five years while keeping Medicaid up-to-date and sustainable.

Conclusion

These are just some of the highlights of our budget proposal. Both the President and I believe that we have crafted a strong, fiscally responsible budget at a challenging time for the Federal government, with the need to further strengthen the economy and continue to protect the homeland.

We look forward to working with Congress, States, and all our other partners to carry out the initiatives President Bush is proposing to build a healthier, safer and more compassionate America.

Now, I will be happy to answer your questions.

Biography of Mike Leavitt

Secretary of Health and Human Services U.S. Department of Health and Human Services



Michael O. Leavitt was sworn in as the 20th Secretary of Health and Human Services on January 26, 2005. As Secretary, he leads the Nation's efforts to protect the health of all Americans and provide essential human services to those in need. He manages one of the largest civilian departments in the federal government, with more than 67,000 employees and a budget that accounts for almost one out of every four federal dollars.

During his first year, he led efforts to successfully enroll tens of millions of seniors and disabled persons in the new Medicare prescription drug benefit; mobilized the nation's pandemic preparedness; accelerated the development of health information technology standards and oversaw the medical response to Hurricane Katrina. He presided over changes in Medicaid statutes to give states flexibility to provide targeted insurance coverage to more people, and worked with Congress to pass the reauthorization of the Temporary Assistance to Needy Families.

During his second year, Leavitt spearheaded the Nation's Health Diplomacy initiative aimed at improving the health of Central Americans and bringing the countries of North and Central America closer together. He also organized a nationwide campaign to transform the Nation's health care sector into a value-driven health care system. He is intensely focused on making health care more transparent in quality and price, and reducing the time and expense of bringing safe and effective drugs to market.

Prior to his current service, Leavitt was head of the U.S. Environmental Protection Agency and served three terms as Governor of Utah.

During his eleven years as Governor, Utah was recognized six times as one of America's best managed states. He was chosen by his peers as Chairman of the National Governors Association, Western Governors Association and Republican Governors.

Prior to his public service, Secretary Leavitt served as president and chief executive officer of a regional insurance firm, establishing it as one of the top insurance brokers in America. He is married to Jacalyn S. Leavitt; they are the parents of five children.

Mr. OBEY. What I am going to do because I understand that she has to leave, I am going to yield my time initially to Ms. Lee because she has to get to another hearing. Then I will go to you, Jim, if that is all right.

Mr. WALSH. That is fine.

Mr. OBEY. Thanks.

Ms. LEE. Thank you, Mr. Chairman. Thank you very much.

Good morning, Mr. Secretary.

Secretary LEAVITT. Good morning.

CENTERS OF EXCELLENCE

Ms. LEE. Well, let me just say first of all, after listening to the testimony yesterday from the Secretary of Education and now hearing your testimony, it is clear that what is being actually cut are initiatives and programs to help those most in need, for example, low income individuals, people of color, communities of color. Here, we are seeing in essence, with your budget, somewhat of the same type of priorities in terms of who wins and who loses.

When you look at racial and ethnic disparities, for example, and I do not believe in your written testimony you mention the need or the requirement, I think, of our Federal Government to address the huge racial and ethnic disparities. But once again, we see the proposal to zero out these programs that would help actually reduce these disparities which lead to shorter life spans, of course, sicker individuals who happen to be Latino, Asian Pacific American or black.

You, again, zeroed out the Minorities Center of Excellence. The scholarships for disadvantaged students are zeroed out, eliminating support, I believe, for over 8,000 under-represented minority students. The Healthcare Opportunities program is also zeroed out.

So I do not know how eliminating over 8,000 scholarships for minority health students really helps us get to where we want to get in terms of a healthy population and in terms of closing these disparities. Also, why in the world would most programs that actually try and do something about racial and ethnic disparities be really level-funded at the most or cut at worst?

I do not understand quite, again, what the assumptions are about the American people, who wins, who loses and why we do not address these disparities in any way. We need more funding if we are going to make sure that there does become equal opportunity in healthcare for all. So I would just like you to respond to that.

Secretary LEAVITT. Ms. Lee, I am not exactly sure what you are referencing with respect to 8,000 minority scholarships, but I would like to just give you.

Ms. LEE. The Health Centers Opportunity program.

Secretary LEAVITT. The number, 8,000, does not resonate with me. Maybe I could give you.

Ms. LEE. That is about how many, I think, minority students are benefitting from that.

Secretary LEAVITT. Let me check that. I cannot validate it or affirm it.

My task was to contribute to the balancing of this budget.

Ms. LEE. I understand.

Secretary LEAVITT. What that means is that I am faced with taking good and noble causes and trying to weigh which ones of those makes sense to continue and which ones, in those conditions, do not. It might be helpful for you to know the criteria that I instructed HHS staff to use.

I told them I wanted to go back and emphasize services as opposed to infrastructure.

I told them I wanted to take programs that were one time funding and look at those as opposed to continuing programs.

I told them I wanted to look at grant activity where the task had been completed and not necessarily reaffirm those.

I told them I wanted to propose places that I could see in HHS which is a very big place. There are a lot of places that we deal with an issue in multiple places, and I wanted to find ways to consolidate those.

So, in many cases, what looks like it may have been a reduction, I may have chosen to do that because we were dealing with that in other places.

When Mr. Kennedy comes, I hope we get a chance to talk about mental health. The Federal Government contributes about 45 percent of all the mental health that goes into.

Ms. LEE. Sure, Mr. Secretary, before my time is up, and I appreciate your explanation with regard to balancing the budget and having to make tough choices.

But I think what I am saying is we all recognize that budgets are moral documents. This budget does reflect certain priorities as you balanced it in terms of who is going to lose. The losers again, once again, just as yesterday we saw, are low income individuals, poor individuals and people of color, and that is a shame and disgrace in this year of 2008.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Walsh.

MEDICAID

Mr. WALSH. Thank you, Mr. Chairman.

Mr. Secretary, let's talk a little bit about those Medicaid regulations that we spoke of. You mentioned that some of the things that the States are doing I think you said are not fair. Could you sort of explain what the rationale is for the regulations that you promulgated?

Apparently, there is about \$13,000,000,000 in savings over 5 years. Why those and what do you think the impact will be on the States?

The obvious impact on Medicaid would be a reduction in spending.

Secretary LEAVITT. Without going through all of the specifics of the rule.

Mr. WALSH. Just generally talk about it.

Secretary LEAVITT. Well, as I indicated, there is this partnership we have with the States, and it is to serve the same people. We serve the same people, and so we have entered into this partnership. We pay part. They pay part. We match their funding.

What the States do on a regular basis is they will hire consultants and the consultants, who get paid a contingency fee on areas

where they can optimize the funding, they will go through and look for any place where they believe they can justify paying for programs that are completely outside Medicaid.

Mr. WALSH. So they are looking for more applications for Medicaid funding for these specific States that we would then be required to co-pay.

Secretary LEAVITT. That is exactly right.

I mean an example is they will take someone in a school whose job is 90 percent—I am pulling that number out of the air—but 90 percent school tasks. They will give them another duty which is to look after a child that might not have health insurance, and then we will pay the entire salary.

Now that is not fair. If they want us to pay 10 percent of it, okay, but not 90 percent of it.

We end up paying for school buses. We end up building buildings. There are States where we are funding with Medicaid, programs in three different departments, none of which have anything to do with healthcare, but they are able to stretch this over. Unless I push back, then they just keep doing it because they get paid a contingency fee.

Mr. WALSH. We saw in the S-CHIP debate that States can liberalize or expand the coverage that is provided not only to kids but to the kids' parents and others, and yet the Administration, the Federal Government, has allowed them to do that when it was not intended for that purpose.

So how do we get our arms around Medicaid benefits and determine is there a one size fits all for the States?

To go even further, again back to the New York State view, if we are paying a dollar for dollar, whatever the Fed puts up a dollar for what New York State puts up a dollar for and the counties have to pay 50 cents of that dollar for the State, it is a huge unfunded mandate on the counties that they have absolutely no control over.

The Medicaid budget in my home county and almost every county in upstate New York is the largest, far and away the largest portion of the budget, and that falls right on the property tax payer. That is one of the reasons why taxes, property taxes, are so high in New York State because the counties pay a disproportionate share of that Medicaid bill.

Secretary LEAVITT. It seems to me there are two issues here. One is the global fairness of the FMAP and whether it is fair for one State to have a different FMAP than another. That is a matter of statute and something that the Congress has dealt with for a long time, and it does not fall at my level of discretion.

However, the second issue, the State has a relationship with the county. As I tell the governors, I hope if your counties are treating you the way that I have felt the Medicaid program has been treated, that you would do the same thing I am doing and try to close down where people are using it for inappropriate things.

I am just looking for some way to focus Medicaid and its limited resources on health issues, not becoming the means by which you can fund every other program in State Government.

Mr. WALSH. What would you cut out? I mean again in the universe of Medicaid spending, what are we paying for now that we should not be paying for?

Secretary LEAVITT. Well, listen, I mentioned case management. We have several rules. We have people that are calling case management things that have nothing to do with medicine.

Also, people have found very innovative ways to finance their match. For example, we give public hospitals a little higher payment. There are a lot of States that are taking that little higher payment, and they are putting it into their general fund, and then they are using our money to pay their match. It is just a cycle.

That is not being fair. That is not being a real partner. So we just want them to put up real money. If we are going to be matching it, it ought to be real money.

That is the kind of thing I am talking about.

Mr. WALSH. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. Roybal-Allard.

STOP ACT

Ms. ROYBAL-ALLARD. Secretary Leavitt, in December of 2006, Congress unanimously passed the STOP Act. It was a bill to address the public health crisis of underage drinking in this Country. The bill and its funding in fiscal year 2008 represented a historical bipartisan and bicameral collaboration that brought together all the members of the public health community and the alcohol beverage industry, all of whom agreed that the programs and grants that were included in the STOP Act were the best Federal response to the crisis of underage drinking.

Given the major scope of the underage drinking problem in this Country and the strong bipartisan support for the STOP Act, why does your budget request propose to actually zero out the STOP Act programs just as they are getting started?

For example, the Community Enhancement Grants under the STOP Act were authorized as four-year grants, the first of which will be funded this year. So how do you justify cutting these grants to communities just one year into that four-year funding cycle?

Secretary LEAVITT. This is an example where we found we were serving a very legitimate need in many different ways, and we opted, as a means of being able to get closer to a balanced budget, to offer communities a means of being helped in alternative ways. They can apply for grants in other ways, and we have made that known to them.

I acknowledge this is an important priority, but this is one where we chose to acknowledge that in many different ways we were serving the same need.

Ms. ROYBAL-ALLARD. Well, with all due respect, the reason we were finally able to bring this, in some ways, unusual coalition of healthcare providers and the alcohol beverage industry together is because those programs and what you had in place were not working.

What the STOP Act actually does is coordinate all the various activities that are being done by the Federal Government by creating an interagency coordinating committee. The Surgeon General himself has said that the Federal Government should fund and actively support the STOP program because this is a different approach

that everyone agrees is going to be much more effective than what has been done already.

It is very, very disappointing. This is a serious crisis in our Country with our children, something that has been worked on for seven years. These groups were not together in the beginning and finally came together and in agreement as to the STOP Act and its provisions were the best way to address the underage problem in this Country.

So it is very disappointing to see that this program is basically eliminated by the lack of funding.

NURSING

On another issue, we are currently facing a dire shortage of nurses in our Nation's hospitals and medical clinics. During the 1970s nursing shortage, Congress appropriated a significant increase in funding for nursing schools and students to help meet that demand.

However, in this nursing shortage crisis, the President's 2009 budget proposal calls for a reduction of 30 percent in Title VIII funding which is a \$46,200,000 decrease in 2008. Why would the Administration so significantly cut Title VIII funding when the programs have been a proven solution to past nursing shortages?

Secretary LEAVITT. This is a budget proposal that we have introduced several times now because we fundamentally believe that we ought to be focused on providing services as opposed to providing infrastructure, but I would like to take up the cause of nurse training for just a moment with you.

I, like you, am concerned about it. I think we are going about it the wrong way.

I think we need to begin to focus on new models of nurse training. We need to be investing in ways and means by which we can utilize the hospitals and utilize the medical training and facilities we have to begin to nurture more and more nurses. We are starting to see models, alternative models like this develop.

You could fill up all the nursing schools in America and increase substantially their capacity, and we still would not be meeting the need that you have eloquently spoken of. We have to change the model, in my view, and begin to focus on competencies and competency-related education as opposed to simply the way we do it now.

But that is a subject for a different day. I know you have other things you want to mention.

Ms. ROYBAL-ALLARD. I would just like to point out, Mr. Secretary, that you will not be able to provide services unless you have the nurses and the health professionals to provide those services. So it is important and should be one of the first steps is to be able to have educated nurses in the system so that you can move towards providing what you are calling the infrastructure and the services.

You cannot have one without the other. And so, by not investing in these programs, you are really undermining your very goal of providing services which are badly needed.

I have another question in regards to the Advanced Education Nursing program. Again, in light of this nursing shortage and the

great need for more primary care providers, again what is the rationale for eliminating the Advanced Education Nursing program that each year helps prepare almost 14,000 graduate nursing students to serve as nursing faculty and advanced practice nurses in rural, urban and under-served areas?

[The information follows:]

NURSING

Secretary LEAVITT. The President's budget directs resources to nursing programs that provide direct patient care in areas where nurses are critically needed through scholarship and loan repayment programs, including an increase of \$16 million for basic nursing programs, including the Nurse Loan Repayment and Scholarship Program, Nursing Workforce Diversity, Nurse Faculty Loan Program, and Nurse Education, Practice, and Retention. Programs for advanced practice nurses may be assumed by surces other than the Federal government, such as, State and local governments, foundations, private sector endowments, and health care organizations.

Secretary LEAVITT. That specific program, I am not sure I have. That is one I am probably going to need to respond to you in writing on. It is at a level of granularity I am not able to respond today at this table.

We are going to be adding funding for 800 nurses in a different part of the budget, but on that specific program, Congresswoman, I think I will need to respond to you. I do not have a response.

Ms. ROYBAL-ALLARD. All right, but that is an important program because it is a program that focuses on nurses who are willing to work in under-served areas. That is very, very critical, given the health problems in many of our under-served and minority communities that just do not have enough professionals working in those areas.

Mr. OBEY. The gentlewoman's time is expired.

Mr. Simpson.

BUDGET SUBMISSION TO OMB

Mr. SIMPSON. Thank you, Mr. Chairman.

Welcome, Secretary Leavitt. It is good to have you here today.

I have several questions I am going to submit for the record because there are too many to talk about, and some things I will ask you about this afternoon at the budget hearing since I am on that Committee also.

You mentioned balancing the budget and the need to participate with the rest of the Federal agencies. I think everybody agrees with that. Could you tell me what your original request was to OMB?

Secretary LEAVITT. Well, as you know, our budget process works like any other budget process where we line up our needs, we line up our wants, and we line up our aspirations, and then we begin to whittle those down.

Mr. SIMPSON. Were any needs whittled away?

Secretary LEAVITT. Well, that is the way budget-making works.

Mr. SIMPSON. I know. I have done it for years.

Secretary LEAVITT. You have to then balance it against different priorities. The same thing in my Department.

Mr. SIMPSON. The reason I asked this, though, is because you have to work with OMB. We do not, essentially.

We look at what the needs are and stuff. OMB might be a participant in that. It might not be a participant in that. But we are not constrained, quite frankly, by OMB like you are.

OMB, quite frankly, sets policy without knowing what they are doing. So I have asked every agency what their original request was to OMB because I want to know what you thought was appropriate to start with, even realizing that you were not going to get it all, because that might be relevant to the Committee in how we make our decisions on what we think is appropriate.

Secretary LEAVITT. I understand. Congressman, I am here to defend the President's budget. There are parts of it that I might have changed.

Mr. SIMPSON. That is fine. I am just asking what you originally requested.

Secretary LEAVITT. Well, my job here is to defend the President's request.

Mr. SIMPSON. Will you get me a copy of what you originally requested?

Secretary LEAVITT. You would have to get that from OMB.

Mr. SIMPSON. See, Mr. Chairman, that bill that I talked about is a good one.

Mr. OBEY. If the gentleman would yield.

Mr. SIMPSON. I would certainly yield.

Mr. OBEY. I mean for years with various administrations, we have gone through these arguments. With all due respect, this Committee has a right to know what the professional experts in the agencies thought would be necessary before the political judgments intervene on the part of OMB.

Mr. SIMPSON. That is exactly my point, and that is why I have been asking the question because I want to know when we make decisions on how we are going to appropriate money. It may be more than you requested. It may be less than you requested. I would like to know what the professionals wanted.

Mr. OBEY. The Administration has a perfect right to make any changes it wants in the agency budgets but, for God's sake, this is not classified material. This is not national security information. People have a right to know what the President is being asked to provide.

The President gives us lectures about transparency, I would like to see a little transparency in the executive branch.

DENTAL HEALTH

Mr. SIMPSON. I agree, and I will start my five minutes over again. Let me ask you a couple of specific questions.

In your fiscal year 2009 highlights, you address the unmet needs for dental care, and I appreciate that. The President added \$11,000,000 to hire 214 dentists—being a former dentist in the real world, that is important to me—through the National Health Service Corps and this is more than has been done before.

However, you eliminated \$19,000,000 for dental programs for training and State projects. What was your rationale for cutting the \$19,000,000 for dental training programs?

Secretary LEAVITT. Well, again, we have tried. There are a lot of places in this budget that touch on dentistry, and we took each program. I had gone through a series of the way we prioritize them.

In some ways, we felt one program was actually delivering services and the other one might be building infrastructure, and we wanted to emphasize limited funds on actually delivering services.

Mr. SIMPSON. Is that what it was, building infrastructure?

Secretary LEAVITT. In fact, we were. In most cases, it was.

Mr. SIMPSON. The Committee increased funding in the fiscal year 2008 budget for the Dental Health Improvement Act from \$2,000,000 to \$5,000,000. The \$2,000,000 covered grants to 18 State projects. Originally, 36 States applied for the funding.

Could you tell the Committee how your Department plans to disburse the new grant money?

[The information follows:]

DENTAL HEALTH

Secretary Leavitt: HRSA is preparing a new competition for the FY 2008 appropriation of \$3 million for Grants to States to Support Oral Health Workforce Activities. This competition will be open to all States, including those that applied in FY 2006 and were not funded. The funding opportunity is planned for release by the end of April and the awards will be made prior to the end of FY 2008.

Secretary LEAVITT. Yes, we can respond in your written questions. We will be happy to respond.

Mr. SIMPSON. Okay.

Last year, the Committee designated \$10,000,000 for the General Practice and Pediatric Dental Residencies programs under Title VII health professionals. Can you tell the Committee how many applicants there were and how many requests were approved and how many were funded?

[The information follows:]

DENTAL HEALTH

Secretary Leavitt: In FY 2007, 40 grant applications were received for the general practice dentistry and pediatric dental residency programs. Of those applicants, 34 were approved for funding and 28 were funded. The dental residency training grant awards totaled \$10,272,394.

Secretary LEAVITT. We will be happy to respond. That is not a level of information that I have.

BONE MARROW DONOR PROGRAM

Mr. SIMPSON. Okay.

One other question, on January 17th, the other members of the Idaho delegation and I sent HRSA a letter regarding recent changes to the rules governing the National Bone Marrow program. Part of those rules are to significantly increase the minority registration requirements.

While recruitment and minority participation are important goals, I am concerned that the new rules do not take into account the demographic reality of States such as Idaho and Utah and put programs such as the one operating in Idaho at risk of closure. Would you be willing to work with me to provide the needed flexibility to accommodate the demographics of all States and regions including my own State of Idaho?

Secretary LEAVITT. Your request has been made known to me previously and understanding the demographic realities of Idaho, yes, we would.

Mr. SIMPSON. I appreciate that, and I look forward to talking to you this afternoon in the Budget Committee about the changes in philosophy to the system rather than the Band-Aids we seem to have been putting on the Medicare and Medicaid system over the years, which is one of my biggest frustrations.

Secretary LEAVITT. Thank you.

Mr. SIMPSON. I appreciate it. Thank you.

Mr. OBEY. Mr. Kennedy.

MEDICAID

Mr. KENNEDY. Thank you, Mr. Chairman.

Welcome, Mr. Secretary.

Rhode Island is probably not unlike a lot of States with a huge deficit it is facing. We have an over \$435,000,000 deficit. It does not sound like a lot, but it is a lot in a small State like mine.

The governor has proposed saving more than \$66,000,000 by reducing Medicaid spending, largely by diverting seniors and disabled adults from nursing homes. The governor says one would not be forced from a nursing home or prevented from entering one, but he needs to divert more than 690 seniors, 300 youths from child welfare services and dozens of developmentally disabled people to less expensive programs to meet the budget targets.

The Department of Human Services Director, Gary Alexander, said the \$66,700,000 is predicated in part on reducing overall number of Medicaid patients in private nursing homes next year by 690. That assumes 125 leave voluntarily, 565 are diverted to other services such as home care. The average number today, 6,500.

The budget also cuts eligibility for the State subsidized healthcare program, Rite Care, for parents with incomes above 185 percent of Federal poverty level which is \$32,000 for a family of 3 to 133 percent, \$23,000 for a family of 3. An estimated 7,396 adults would be affected.

The governor also wants to cut the school breakfast program entirely, eliminating State funds for the program, thinking that the Federal Government will somehow come in and operate the program without State subsidies. How that will be done, I do not know.

The eligibility for the State's welfare program known as the Family Independence Program will also be cut by two years as well as huge, substantial cuts in Head Start, Rhode Island Meals on Wheels, Crossroads Rhode Island, Rhode Island Community Food Bank.

The point I am making is: Has the President of the United States coordinated with my governor, Governor Carcieri—both of them talk quite frequently—about the cumulative impact of the budgets that the President is proposing and Governor Carcieri is proposing?

Has there been any connection? Because if you are looking at your budget on top of what we are doing in Rhode Island, there is a disconnect.

Secretary LEAVITT. Well, you read a long list of things there. There are some where they would undoubtedly come to HHS and say, here are some impacts we are having. Can you help us with this or do we have an authority to do that?

Mr. KENNEDY. Right. Right.

Secretary LEAVITT. One, for example, is in the area of diverting people from nursing homes. We see that as a positive, and we would be anxious to cooperate in seeing that occur. We would like to see people cared for where they want to be, in a way they would like to be. Frankly, it is less expensive and people like it.

So, to the extent that we are cooperating on programs where we have overlapping jurisdiction, the answer would be yes. In terms of coordinating the development of our budget, no.

Mr. KENNEDY. But you cut administration on aging. I mean you cut administration on aging. You cut the kinds of programs that are going to help us be able to do these things. Of course, these other programs that are being eliminated are not going to make these problems easier.

All I am saying is I do not know to what extent there has been any Federal coordination from Washington with these States. These are all difficult. Some of these States are going to be in a really particularly difficult time.

Is there any connection between you and your respective counterpart at our State level in terms of the cumulative impact between what this is offering and what is going on at the State level?

Secretary LEAVITT. I hear regularly from States as to the impact that the Federal budget, one way or the other, will have on their budgets.

Mr. KENNEDY. Yes.

Secretary LEAVITT. Obviously, they do their budget. We do ours. Sometimes what they do has an impact on us as well. For example, we mentioned earlier changes that States have made in Medicaid where, frankly, we have pushed back because they have an impact on our budget.

Mr. KENNEDY. Yes.

Secretary LEAVITT. We have seen situations where we do things that they push back, and so there is a push and pull. It happens, but we do our budget independently. I am sure that the effect is, at times, cumulative.

Mr. KENNEDY. We are all serving the same people.

Secretary LEAVITT. We are.

MENTAL HEALTH

Mr. KENNEDY. I just get concerned. One of the things that I want us to look obviously more at is the holistic view of this and not in a stovepipe mentality that this is a Federal program and this is a State program. It is how we are working together.

One of the things this year obviously is—I know you mentioned before I came about mental health programs—that this year we get a better sense of all mental health research under HHS.

A lot of the mental health research that is going on is going on at the VA now because of traumatic brain injury and because of post traumatic stress disorder. A lot of it is going on in DOD because of the obvious interest that the Department of Defense has

for those same reasons. A lot of it is going on in other agencies as well.

We are really interested in making sure, even with NIH. There is a whole plethora of brain and nervous-related research that goes on that is not coordinated with NIH.

So would you be willing to work with us to try to coordinate the existing research that goes on within the Federal Government under HHS so that we can get it to the FDA and professionalize more FDA in terms of brain/nervous system research so that this brain and mental health related research can get out to the public in a more expedited way?

We found that with all the dollars that we are spending right now approximately \$6,000,000,000 through the NIH and over an additional \$3,500,000,000 through other agencies. It is really not being organized, and the one hand does not often know what the other is doing. We find that for an additional \$200,000,000 we can coordinate it.

If we professionalize the FDA more, we would better be able to get that out to the public maybe through some SBIR efforts as well. We would love to work with you on that.

Secretary LEAVITT. I am a big believer, first of all, that government is way too siloed. That is true inside HHS as well as throughout the broad government.

I would argue that the better place to coordinate it might be NIH, not FDA, but nevertheless I am certainly in agreement and willing to be a participant in better coordination.

Mr. KENNEDY. Okay, great.

Well, I appreciate the increases in drug courts and mental health courts. Obviously, I am distressed about the overall cuts in substance abuse prevention and funding services and mental health prevention, SAMHSA, but I know we will look forward to working with you to rectify some of those cuts.

Secretary LEAVITT. Thank you.

Mr. OBEY. Mr. Weldon.

Let me explain to the Committee, we have this vote going on. What I would like to do is to get through Mr. Weldon's five minutes of questions and then break to go vote.

Mr. WELDON. Thank you, Mr. Chairman.

Secretary Leavitt, it is a pleasure to see you again.

Secretary LEAVITT. Thank you.

AUTISM

Mr. WELDON. I want to commend you for your service. You have a tough job. I am not sure how many opportunities I will have to see you between now and when I leave. I am retiring at the end of this year.

I did want to bring up a budget issue related to your agency, and that is the vaccine/autism connection question. I appreciate the concern that you have expressed about this issue and the time you have taken to meet with me in the past.

I do not know if your staff has brought it to your attention. We had a lot of discussion in the Committee about the mercury issue and should we mandate the mercury getting out, but there was a

case that was settled in the vaccine claim court. Are you aware of it?

Secretary LEAVITT. I am aware of that.

Mr. WELDON. It involved a claim that a mercury-containing vaccine was the cause of the autism. Your legal counsel, using appropriate legal language, said, "concluded that compensation is appropriate."

I think that is about as far as they went in the commentary, but the thing that caught my interest is one of the doctors who was involved with the case.

Just so members of the Committee know, it was a little girl, again with regressive autism. The parents claim she was fine. She got her shots, became autistic, and the claim was that the mercury was responsible and a settlement, a lifetime settlement now. The Federal Government is going to be paying for this kid's care.

But one of the doctors involved claimed it was this mitochondrial disorder. Do you know about that part?

Secretary LEAVITT. I know sketchy details about the suit and about the litigation and the fact that it was settled.

Mr. WELDON. Okay. Well, let me tell you what caught my attention about the case. This Dr. Zimmerman published in the Journal of Child Neurology, a respected journal, that their research shows that 38 percent of kids with autism have 1 marker for this condition, 47 percent have a second marker.

As I understand it, all these doctors taking care of these autistic kids now are going back and testing these kids for this mitochondrial disorder.

If this pans out, granted, this has to be validated and there has to be a lot more research on it, but if it pans out, just my back of the envelope estimation is we have 500,000 kids with autism today in America. If you just assume an average payout to care for the child over the course of its life of a million dollars, it could be a \$500,000,000,000 claim against HHS, hopefully not in one year, Mr. Chairman.

What really, I guess, kind of forced me to bring this up today, and I realize this is not going to be perhaps your problem to deal with. It will be whoever follows you. Did you see this ad in the USA Today yesterday, a full page ad?

Secretary LEAVITT. I did not. I did not.

Mr. WELDON. One of the guys who helped fund it was Jim Carrey of all people, you know, the guy who played the Grinch in that movie. But, basically, they are indicting the vaccine program as the cause.

Over the last 10 years, I have had just dozens and dozens and dozens of parents say to me: My kid was normal. My kid got the vaccines. My kid became autistic.

A lot of the professionals in the pediatric community have been just pooh-poohing it and pooh-poohing it.

This is, in my opinion, a huge issue from two aspects for HHS and for CDC and for the medical profession and the pediatric profession. Obviously, if something like this is ultimately determined to be true, there are huge financial consequences for the government, but as well it undermines the integrity of our vaccine program, and these vaccines do save lives.

Now I know you have responded and NIH has responded, and the amount of research dollars has increased significantly. I just wanted you to be aware of some of the details of this. I do not expect you to respond to what I am saying.

And I just wanted to bring it up before the Committee that this could, if this is ultimately shown to be true and the complaints of thousands of parents for the last 10 years ultimately are shown to be valid, it could have huge, gigantic implications for budget and as well for the public confidence and integrity in our medical profession and in our vaccine program. Obviously, whoever follows in your footsteps could end up having to deal with this.

Secretary LEAVITT. Mr. Chairman, may I just respond briefly?

I hear those voices. No one can hear them and not feel compassion, and yet the finest scientific minds we have in this government at CDC continue to tell me that the basis, scientifically, is not there.

So I hear the voices. I respond to them, but I think it is important in the context of what you said to recognize that there is another side to this story and it will undoubtedly play out in lots of ways over the course of time.

Mr. OBEY. I would suggest we go vote.

[Recess.]

Mr. OBEY. The Committee will come to order.

Mr. Secretary, we have lost the inmates. [Laughter.]

Mr. PETERSON. We have lost the inmates. One inmate is here.

Mr. OBEY. Let's see. Who is it?

All right, Mr. Udall.

RURAL HEALTH

Mr. UDALL. Thank you, Mr. Chairman.

Mr. Secretary, thank you so much for being here today, and we really appreciate your service.

You are from the West. You were governor of Utah for 11 years. You are familiar with some of the challenges that western States with rural populations face in delivering quality and affordable healthcare, and you are aware of the access problems residents of the West have.

Yet, again, you come to us with a budget that absolutely decimates programs for rural healthcare. It also is yet again a series of classic unfortunate robbing Peter to pay Paul scenarios. It is more of the same bad ideas that have been rejected time and time again, and yet here we are.

I want to ask you specifically about the rural healthcare programs and Title VII in particular. As you know, Mr. Secretary, when you have rural areas and they are under-served, it is very, very difficult to get physicians and nurses and other healthcare professionals out into those areas.

When I look at your budget here—National Health Service Corps, health professions, Title VII non-nursing—I mean that is completely eliminated. Title VII non-nursing goes completely eliminated and a cut to national service health care. Could you explain to me what you are thinking about there and putting on your western hat here if you can?

Secretary LEAVITT. Thank you. I am proud of being a westerner, and I do, as a result, have some sensitivity on rural health.

I would like to recognize and remember that in 2003 Medicare Modernization Act, we added \$25,000,000,000 that we believe will raise the level generally in those areas. I would also like to ask you to recognize that we have added in this budget 800 new nurses and 200 new doctors, and many of those will be focused in under-served areas.

I would also point out that some of the programs that we have de-emphasized, we de-emphasized because they were not particularly effective. Only 35 percent of the individuals trained and supported in some cases, in some of our programs, went into medically under-served areas. We did not think they were working, so we have tried to emphasize other programs to meet the need you have spoken of.

Mr. UDALL. Mr. Secretary, I must say that I find that explanation unconvincing, and the reason is the provisions in the MMA were never meant to replace the HHS Rural Healthcare Grant programs.

The MMA was about preserving access and helping providers keep their doors open. The MMA even reauthorized the Rural Hospital Flexibility program which is eliminated by your budget. The MMA provisions also have all expired and Congress has yet to extend them.

The HHS grant programs are meant to improve healthcare quality and innovation in rural areas. Even with the benefit of the MMA, many rural providers still struggle with costs. The proposed cuts only roll back the clock on rural healthcare.

I think you are going to see some bipartisan opposition on this basis.

Once again, back to Title VII, the Administration has maintained its reason for not funding them is they are ineffective. This Committee has restored some of the funding because we know they are important programs.

Could you tell the Committee when the Department seeks grant applicants for these funds, the nurses, the doctors that are going into rural areas, do you get more approved requests than you can fund?

[The information follows:]

RURAL HEALTH

Secretary Leavitt: Appropriations received for Titles VII and VIII programs must first be utilized to fund non-competing continuations and then the remaining funds are used to support new applications. On average, 34% of approved applications are funded.

Secretary LEAVITT. I do not know at this table today whether that is true or not. I will respond to you in writing if you would like, but I am not able to respond.

Mr. UDALL. Do you have anybody with you?

I mean I would be amazed if we did not get a lot more. You just do not know?

Secretary LEAVITT. You have stumped the panel.

COMMUNITY HEALTH CENTERS

Mr. UDALL. Oh, with all those health experts out there, hard to believe that.

Let me see how I am doing on time here.

Could you talk to me about the community health centers and what you are intending to do there, Secretary Leavitt?

Secretary LEAVITT. Well, as you know, the President set a goal to have 1,200 new or expanded health centers. We have now met that.

We continue to move forward. We are focusing on areas that have low income, particularly in low income communities.

Mr. UDALL. Is this going to take away from existing centers?

Secretary LEAVITT. No. We intend to expand the number. We have actually met that goal. In the last fall, we hit the 1,200th new or expanded center.

We have intended to try to use them to serve broader populations including, in some cases in urban areas, Indian health needs in this budget. We see community health centers as continuing to be a very important part of the way we serve underserved populations.

Mr. UDALL. Great. Thank you very much, and I hope maybe to ask you about some of the Native American issues in another round.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Peterson.

Mr. PETERSON. Thank you, Secretary. Welcome to the Committee and thank you for your service.

Secretary LEAVITT. Thank you.

MEDPAC

Mr. PETERSON. I guess my predecessor here just teed up the issue. I am from rural. I represent the second most rural district east of the Mississippi. I have 17 hospitals in my rural district.

I guess when I came to Washington, I had chaired health at the State level for a decade and worked on the issues for 19 years as House and Senate member. I guess I was just stunned at the lack of attention to rural. I mean between 28 and 30 percent of our Medicare/Medicaid recipients are in rural.

So I guess the first issue I would like to ask you is I know you do not appoint them, but how do we get a fair representation of people from rural on MedPAC?

The deck is stacked. We are used to that. Urban/suburban health interests always dominate.

When I first became House member in the Pennsylvania Legislature, the hospital association and I became good friends and it was because I had been on a hospital board and health issues were important. But I soon learned that my rural hospitals had a different message than the State association had because they are rural and the State associations are driven by suburban/urban because of volume numbers and dues they pay. I understand how it works.

But the process here of having it fair, I mean 30 percent of America is rural. We have maybe one member on MedPAC that

really understands rural. Some say you might give credit of one and a half or two but one for sure that really does.

We ought to have five people on MedPAC that understand rural healthcare when they make their decisions, that they are not all urban/suburban slanted decisions.

Could you help us with that? Can you play a role in that? You come from a lot of rural area.

Secretary LEAVITT. I wish I had advice for you today on the MedPAC appointment process. I do not. I think it is a split between a number of different sources.

Mr. PETERSON. Well, GAO recommends them. We do not approve them.

Secretary LEAVITT. I have a vague understanding of this, but I believe that there are those that are nominated from a number of different sources, and the belief must have been that if you have people nominating from a number of different sources, you will get a more balanced view.

I do not know the dynamics, and I do not know why there have not been as many rural members as you believe, but I am sympathetic to your view.

Let me just make one other point—and that is something we have not focused as much as I think we should when it comes to rural health—is the positive impact that Medicare Advantage has had.

We are seeing a lot of people who are signing up for Medicare Advantage being in rural areas and particularly those who are in under-served populations and minority communities, and they are doing it because they have an easier opportunity and a better chance to get a physician. We are seeing fewer problems in that area under those who are enrolled in Medicare Advantage.

MEDICARE ADVANTAGE

Mr. PETERSON. Well, yes, it has helped in part of my district, but I have counties that do not have a shot at that too. I have areas that that has not penetrated.

I was just told we have 20,000 Medicare recipients, but I am sure we have more that do not have that option. You do not have that option where I live, to be part of Medicare Advantage.

But I guess the part in your budget, and we just heard a little bit about it, whether it is rural outreach, rural flex, rural access to emergency, rural community facilities, CSGB, the rural issues, and I have found this across other budget lines.

I mean for some reason this Administration's OMB does not appreciate rural. They are small programs, and they like to cut small programs. They just whack them. But these programs, you know we get measurably less for the same treatment.

I had a member of Congress my first year here tell me, oh, John, I am from rural too, but we need to close rural hospitals to save money.

And I said, how are you going to save money because when you close a rural center or hospital, they matriculate to an urban center who gets paid 30, 40 or 50 percent more for the same procedure? So nobody saves any money.

The constituents are disadvantaged. They are further from home, and that is not a part of the healing process when you are 150 miles from home in an urban area. It is a crazy system.

I have been in business all my life. When we go to Wal-Mart or Target, the big store, we expect to pay the bottom price. When we got to the little stores, we expect to pay more.

Well, healthcare is the only place where it is inverted where the little guy gets paid less. He still has to have MRI services and CAT scan services and all these other diagnostic tools. He does not get to use them as often to pay for them, but we pay him measurably less. That is the only business in America that gets the short end of the stick right off the bat.

Then we have these little grants that we do to try to help rural hospitals recruit doctors, help them be competitive, and we eliminate them. How does that happen?

Secretary LEAVITT. If you are complaining about the differential pricing, and you should, I am with you. I think the system we use in setting prices in Medicare is antiquated, wrong, illogical and ineffective, and I think the fact that your statement points out. We subsidize the wrong things, and we overpay things we should not. It is because there is no market sensitivity, and we have a price-setting model. How else can you justify the wide variance between one State, one region, one county? You can take counties in particular areas and see 10 miles from another place, they get paid a lot more for the same procedure.

Mr. PETERSON. Suburban/urban MSA.

Secretary LEAVITT. I cannot justify that system. I would change that system if I had the sole power to do so.

Mr. PETERSON. Have you ever proposed that to Congress?

Secretary LEAVITT. We have had a lengthy conversation. Yes, I mean it has been proposed many times.

Mr. PETERSON. But how do you rationalize cutting?

You have admitted. You have agreed with me. It is inequitable. But these outreach grants, flexibility grants, these help the little guys kind of keep it together, and you take away the little support system we have because we know they are not paid fairly.

Secretary LEAVITT. Well, Congressman, we could go through each and I could give you my justification. We have done the best we can to be sensitive to the need and balance the budget.

Mr. OBEY. The gentleman's time is expired.

Mr. PETERSON. I will take a dollar cut in rural for every dollar cut urban gets, but that does not happen.

Mr. OBEY. Mr. Jackson.

TITLE VII HEALTH PROFESSIONS

Mr. JACKSON. Thank you, Mr. Chairman.

Secretary Leavitt, welcome back to this Subcommittee and thank you for your testimony and for your service to the Nation.

With that said, Mr. Secretary, I cannot tell you how disappointed I am in this budget.

In your written testimony, you say throughout the entirety of this Administration's two terms, the President has sought to increase access to affordable healthcare, protect our Nation against

health threats, advance medical research and “serve the needs of our most vulnerable citizens.”

Yet, your budget says the exact opposite because it eliminates all funding for Title VII health professions programs.

Again, according to your written testimony, I assume you are going to justify eliminating funding for these programs by saying, we have identified under-performing, inefficient or duplicative programs and redirected our resources to programs that provide a greater benefit for our tax dollars.

Your written testimony leaves me with a couple of questions. If under-performance, inefficiency or duplication is the justification for eliminating Title VII funding, number one, what program or programs have you identified that provide a greater benefit for our tax dollars and accomplish what Title VII actually does?

Secondly, if under-performance and inefficiency are reasons to terminate programs, then why do we continue to not only ask for funds for abstinence only education but ask for increases when study after study shows that abstinence only education does not work?

Who in the Administration has determined that Title VII health professions is under-performing, inefficient or duplicative?

I hope you do not say OMB because when my constituents need healthcare advice, they do not go to H&R Block and request it.

Five years ago, the National Academy of Sciences, the Institute of Medicine wrote a report called Unequal Treatment Confronting Racial and Ethnic Disparities in Healthcare at the insistence of this Committee so that this Committee might have a path for funding programs that could close profound gaps that exist in our society. We needed a road map.

To end ethnic and racial disparities in healthcare, the report stated we must, one, increase the proportion of under-represented U.S. racial or ethnic minorities among health professionals. To the extent largely permissible, affirmative action and other efforts are needed to increase the proportion of under-represented U.S. racial and ethnic minorities among health professionals.

So the recommendation of the M.D.s and the Ph.D.s, not the bean counters, is to increase the diversity of health professions, exactly what Title VII does.

From your perspective, Mr. Secretary, what do you propose funding that does exactly what Title VII does?

Secretary LEAVITT. We are proposing the funding of 800 new nurses and 200 new dentists as a very good example.

We believe that comprehensive abstinence sex education is, in fact, effective. I know you disagree.

I suspect we would disagree on many of the decisions we have made, but nevertheless they are our judgments and we put them forward as our budget.

Mr. JACKSON. Mr. Secretary, I have a report prepared 15 months ago by two M.D.s from your Health Resources and Services Administration, from HRSA. This report, in essence prepared by your Department, says:

“One, under-represented minority health professionals, particularly physicians, disproportionately serve minority and other medically under-served populations;

Two, minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care and mental health settings; and

Three, non-English speaking patients experience better interpersonal care, greater medical comprehension and greater likelihood of keeping follow-up appointments when they see a language concordant practitioner.”

Your report goes on to say, these findings indicate the greater health professions diversity will likely lead to improved public health by increasing access to care for under-served populations and by increasing opportunities for minority patients to see practitioners with whom they share a common race, ethnicity or language.

Race, ethnicity and language concordance, which is associated with better patient-practitioner relationships and communication, may increase patients’ likelihood of receiving and accepting appropriate medical care.

Mr. Secretary, your agency’s October, 2006 study makes a pretty strong case for support of programs which contribute to workforce diversity such as COE and the HCOP program. The Administration’s budget again contradicts the recommendations of the M.D.s in this report and other science-based evidence which I have presented to the Subcommittee in the past.

Mr. Secretary, is ending healthcare disparities really a priority for this Administration and, if so, why should we listen to the people at OMB over the M.Ds and the Ph.Ds who are recommending a completely different strategy?

Secretary LEAVITT. Well, again, I will point to the 800 new nurses and 200 new dentists, and I will make clear that we are making it a priority and believe, as you have suggested, what the report reflects. We need to focus and target those areas, and we think that is what we are doing here.

Mr. JACKSON. Mr. Chairman, I plan to offer amendments in Subcommittee and at full Committee that will restore Title VII to current funding levels, and I would ask the support of the Committee in offering those amendments at the appropriate time and, if necessary, I plan to make my case regarding Title VII on the floor.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. McCollum.

HEAD START

Ms. MCCOLLUM. Thank you, Mr. Chair.

Secretary Leavitt, you have been asked about workforce a lot, and I want to talk about the future workforce, the children of this Country. I was, to say the least, very disappointed in the Administration’s budget proposal in its approaches to services for children.

To remain competitive in a global economy, we need our children to be not just educated but well educated. We need them to be safe, and we need them to be healthy.

Your budget flat funds maternal/child health in Healthy Start. It eliminates newborn hearing screening which is a very popular thing. It gets eliminated all the time. We know that if early detection for hearing loss is found, it makes all the difference in a child’s

ability to communicate and cuts down the special education costs, saves so much money for the Federal Government at the other end.

You flat fund childcare and welfare programs at a time where families are struggling with rising fuel oil and food prices.

Head Start gets a small increase. You were a governor. You know how many kids you had on your waiting list for Head Start, and I do not see us moving forward to really eliminate the waiting list for Head Start under this program.

Now if you believe in investing and if you know in that investment you are going to have a return on your dollars, it would seem very shortsighted to me not to focus on and fund these children's services because we know scientific information is out there that there is significant improvements in their life and their health.

So I do not know how we can expect to compete as a Country if we as a Country are not doing what is in our capability to make all children succeed. So can you tell me what is your rationale for flat funding programs?

I want to point out something I do in my district. President Bush and I came to the Hill at the same time. He was in the White House, and I was in Longworth.

But I can figure out math pretty good. If I have a program and it is cut, zeroed out, everybody comes in and scrambles. We fund it at 75 percent. Zeroed out the next year. Everybody comes in and scrambles at 75 percent. Zeroed out again.

So this flat funding and these cuts are more than just this year. This has been going on for a long time.

Can you tell me what your proposal is to do about the children in this Country who continue to be on a waiting list?

Secretary LEAVITT. Congresswoman, again, let me indicate I agree many of the proposals you have referenced have been proposals we have made several years concurring because we do not believe that they are an effective or efficient way to serve those populations.

You talked about children's health. I will remind you that the President's budget has a nearly \$20,000,000,000 increase for SCHIP which will increase the number of children that are being covered. We believe that it is consistent with our view.

Ms. MCCOLLUM. Sir, I asked you. Let's just stick with Head Start then because you just said Head Start is a program that did not work.

Secretary LEAVITT. No, I did not say Head Start. No, I did not.

Ms. MCCOLLUM. You said we cut programs that did not work. That is why I am giving you an opportunity to go back.

Secretary LEAVITT. What you said earlier was we did fund Head Start with a slight increase, and then you listed a number of programs that we did not.

What I suggested to you was there are a number of programs that we have year after year proposed that they either be reduced or eliminated.

We have done that this year on the basis of whether they were providing direct services as opposed to infrastructure, whether it was one-time funding that may have existed. We looked at grant activity that, in fact, had been completed. We looked for programs where we were serving the same need in different places.

Many of the programs that you have referenced, and you have given me a long list, fall into each of those categories.

We also looked for places where, well, I think I have mentioned the fact that many of the programs you have talked about, we fund in different ways.

Ms. MCCOLLUM. Well, sir, Head Start, the dollars that you have in this budget for Head Start will not even serve the current number of children we are serving, let alone address the waiting list.

Secretary LEAVITT. I do not think that is correct. We will fund, in fact, those that are there, and we will add to it. This budget accomplishes that. It does not take care of the entire waiting list, I acknowledge, but it does in fact cover more children.

Ms. MCCOLLUM. How much is the increase for Head Start?

Secretary LEAVITT. One hundred and forty-nine million dollars.

Ms. MCCOLLUM. One hundred and forty-nine million, does that cover transportation costs that the Head Start centers are going to have to absorb?

Secretary LEAVITT. Well, it is \$149,000,000 more money. It is an additional appropriation. I suspect it will be different in every case. Every Head Start program will manage their program according to their priorities.

Ms. MCCOLLUM. Secretary Leavitt, I would very much appreciate if you would break out for me how this current budget takes in account all the inflationary increases that we know are out there so that I know, at a minimum, no children will be removed from the Head Start rolls.

Secretary LEAVITT. I do not represent that we are covering inflation for every program.

I am, however, representing that we are adding additional dollars to the Head Start program that by our calculation will not only cover existing children but a small population increase of others.

Ms. MCCOLLUM. Mr. Chairman, if we are not covering inflation for programs, how can programs be expected to serve the same numbers?

Mr. OBEY. Well, all I would say is that it has long been my point that if you do not adjust for both inflation and population growth, then you in fact have a real per capita reduction in services in any program that does not do that.

Ms. MCCOLLUM. Thank you, Mr. Chair.

Mr. OBEY. Very belatedly, Mr. Rehberg. I am sorry.

LIHEAP

Mr. REHBERG. Mr. Chairman, that was Archie on your shoulder, saying, do not forget me.

Secretary Leavitt, I find myself in the unique position with the untimely retirement of Mr. Peterson of taking up the banner of natural gas. I hope I can get your charts to present to this Committee in particular because this Congress has a difficult time recognizing the connection between American energy and low income energy assistance.

While we limit our access to our own supply and the very people, the majority of the people that are both voting and on the East and the West Coast that are exacerbating the problem are usually the ones that are stepping forward and saying, what about our poor

that cannot afford their home heating because of the price of energy?

The solution is American energy. We have natural gas off both our east shore and west shore that is inaccessible. Enough being said to that because I know this Administration is recognizing that.

But in this budget then, the low income energy assistance, you have brought a budget forward that is at least \$800,000,000 less for low income energy assistance than in the last budget. Is that in anticipation that Congress is going to come to their senses and open up new sources of energy because the price of energy is going up?

Or, is it a recognition that we will always backfill with emergency dollars and so Congress will do the right thing and appropriate the money to help the low income?

Or, is it just you are using the money to balance the budget and Congress, you figure the problem out?

Secretary LEAVITT. Well, Congressman, without respect to making a statement on energy policy which is not in my portfolio.

Mr. REHBERG. But you certainly understand the issue.

Secretary LEAVITT. I certainly do, and I thought your words were eloquent on that matter.

We do have a commitment under LIHEAP to help those who have high energy bills and who cannot afford them, and we meet that. The Administration has long demonstrated a willingness to appropriate more money when it was needed.

We estimated what we thought would be needed this year and put it in the budget. If it turns out we need more, then the Administration obviously would step up and support whatever was necessary to meet that obligation.

Mr. REHBERG. I guess I do not understand how the Administration can take the position that it is anticipated to be less costly than the prior year based upon a 7 percent increase in natural gas prices, 50 cents per gallon in propane. Just the cost of the energy alone is going to force additional revenues necessary.

Secretary LEAVITT. If it turns out that is the case, then we will be happy to cooperate in solving that problem.

Mr. REHBERG. Okay.

One of the things that happens to us and you having been a governor and me being in the executive branch at one time as well, we tend to point fingers somewhere else other than ourselves. So we have a governor in Montana that is pointing a finger at you, saying, you did not get our low income energy money out to Montana soon enough.

As we do the research, it looks as if you did it on a timely basis, but they did not get it out in a timely way. There is somehow a lack of a sense of urgency within the State of Montana to distribute the funds.

And so, I guess my question is do you, within the Administration, have a mechanism that requires States to get the money out to the people that need it in a timely fashion so that we do not have all the finger-pointing because a sense of urgency does matter when people are cold?

Secretary LEAVITT. We allocate on as timely a basis as we know, or know how to, the money when it is needed.

Mr. REHBERG. But do you require then the States to turn it around?

Secretary LEAVITT. The States essentially act from that point forward on their own timetables.

Mr. REHBERG. Could there be or should there be some kind of a mechanism within our appropriation or maybe an authorization requiring the States to have a rapid turnaround because you can see the problem?

It happens with bureaucracies. They sit on the money or they have their own thing they have to go through. At a time of emergency, which is what I assume low income energy assistance is supposed to be about, should not there be some kind of a mechanism requiring States to turn the money around faster?

Secretary LEAVITT. Again, the federalist in me will come out here and suggest that I think we are probably better off maintaining a limited role of the Federal Government and allowing those who are closest to the problem. Now, if they do not respond, then their voters ought to hold them accountable, but our job is—

Mr. REHBERG. But they are blaming you.

Secretary LEAVITT. Well, there is nothing new about that. I have come to understand that that is part of this job, but another part of the job is to make certain people have LIHEAP funds when they need it. We will do our best to meet that demand.

COMMUNITY PHARMACIES

Mr. REHBERG. The second question then having to do with the community pharmacies, and thank you for the community health centers. They are working very efficiently and effectively in Montana.

Mr. Peterson, I have 67 hospitals in my district. So I certainly know what rural health is all about.

The rural pharmacies are having difficulty because of the reimbursement time in the Medicare Part D. Is there something going on within your Administration to speed up the time difficulties in the reimbursement?

Secretary LEAVITT. Well, we have made clear to the payers or to the plans that they need to meet their contractual obligations, and if they do not meet their contractual obligations, then we are prepared to use the force of Federal law to assure that they do.

However, the problem with the pharmacy, between the pharmacies and the plans is that they have negotiated contracts, and the pharmacies and the plans need to work out different reimbursements if, in fact, that is not meeting the need of rural pharmacies.

Mr. REHBERG. Unfortunately, part of the problem is that the plans do not necessarily have to negotiate fairly with the small rural pharmacies, and so they are at a negotiating disadvantage. So it would be nice if you had the ability to require the plans, if they file electronically, to do it in a much more timely fashion.

Mr. OBEY. The gentleman's time is expired.

Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman.

Welcome, Secretary Leavitt.

Secretary LEAVITT. Thank you.

TUBERCULOSIS

Mr. HONDA. Under the CDC budget justification, you indicate that there is a decline of TB cases in the United States. However, you have a designation called the CDC Metropolitan Area for Special Attention relative to TB, and that is where Baltimore, San Francisco and New York City have a funding level of about \$10,000 per case of TB.

Santa Clara County, however, has only \$4,000 per case. In California, we represent probably the largest incidents, well, 20 percent of the Nation's TB cases, and Santa Clara County has the largest incidents of that. What do we have to do in order to have the same funding level as the other three cities or how do we become a CDC Metropolitan Area for Special Attention relative to TB?

[The information follows:]

TUBERCULOSIS

Secretary Leavitt: The number of TB cases in the U.S. has declined by almost 50% since 1992, due to the successful implementation of effective TB prevention and control strategies. CDC publishes TB surveillance data by state as well as metropolitan statistical area (MSAs) with populations greater than 500,000. In California, the following MSAs have the highest number of cases of TB in 2006 (in descending order): Los Angeles, San Francisco, San Diego, and Santa Clara. Only a few large cities in the United States receive direct funding from CDC for TB control. Most large cities in the United States receive federal funds from allocations made to them by the States. In addition to allocating federal funds to local governments, the States (primarily public health departments) provide vital support to TB related activities including: surveillance, training, outbreak response, and medical consultation.

At percent, CDC allocates 35% of its TB grant funds based on current case numbers and other factors complicating the treatment of those cases. As a result of the TB formula, CDC increased funds allocated to the State of California by slightly over one million dollars (adjusted for a Congressional rescission) in FY 2008. In turn, it is our understanding that the state of California distributed its funding using a formula that was determined by the State.

Secretary LEAVITT. I do not know the answer to that. I would be happy to respond to you in writing as to what the formula is, but sitting at this table today I do not know the answer.

Mr. HONDA. Sure, okay. It might be helpful also if you would direct us to an individual that we can work with also.

Secretary LEAVITT. Thank you.

HEPATITIS

Mr. HONDA. In the area of hepatitis, the Division of Viral Hepatitis has essentially been flat funded for the past four years, and it has been stated before that flat funding is essentially a passive cut, if you will, in budgets.

It was stated that the acute hepatitis cases have decreased, but the number of chronic cases continues to grow. In the area of Hep B, that is about 100 times more which is 100 times more infectious than HIV. In some communities such as Asian American communities, Hep B has high incidents.

I was concerned that those who do not receive treatment will essentially end up with cirrhosis of the liver or liver cancer. In light of those costs to our Country both in human costs and real costs, I would like to just indicate that and urge CDC to look at it again and find ways to increase the funding at least in those areas.

I understand that you are trying to meet what we call fiscal responsibility, but I think that given the ways we have been spending money in the last few years, we might be able to find ways to sort of get a bit more money in that area.

Secretary LEAVITT. I was, earlier this week, visiting some homeless shelters, and I spent time on a van that is in part paid for, in major part paid for by programs you have spoken of where we go out into communities and seek out those who might be suffering. I was told by a physician who operated the van that hepatitis is one of the most common things they are seeing and while it is not necessarily increasing, they see it on a regular basis.

So your words resonate with me. I understand what you are saying.

Mr. HONDA. Yes. That might be Hep C.

Focusing just on Hep B which affects a population of about 12 million, that is Asian Americans in this Country, and these are not homeless folks but people who travel a lot or people who do not know that they are carriers.

We know that there are ways to treat it if we can find it in time. Having community programs like health fairs where we can test folks, we might be able to prevent a greater cost in the future in terms of the chronic forms of Hep B.

Secretary LEAVITT. Well, thank you for informing me.

Mr. HONDA. Perhaps you folks can look at that and maybe work with our community. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Mrs. Lowey.

SKIN CANCER

Mrs. LOWEY. Thank you and welcome, Mr. Secretary. The absence of many of us have nothing to do with the interest of this hearing but other responsibilities at other committees. I am delighted to have a chance to have a conversation with you about a few key issues that have been concerning me.

You know that over one million in the United States are diagnosed with skin cancer each year, and the cancer is preventable with the proper use of sunscreen. But what we have seen in many of these studies is people who lather themselves with sunscreen. If it does not protect against the appropriate UV rays, it does not do them any good, and they are the ones that are getting melanoma and other kinds of cancers.

Unfortunately, as you know, there are no standards for how much protection sunscreens must provide against the ultraviolet rays that cause skin cancer. I introduced legislation last year requiring the FDA to create such standards and HHS to conduct a public awareness campaign about the dangers of overexposure to the sun and ways to protect oneself.

Last August, in response to my legislation, the FDA proposed new standards that will better inform consumers of the level of protection that a product offers against skin cancer-causing rays.

Now I understand that FDA is not under the jurisdiction of the Committee, but I would expect that you would be working with Commissioner von Eschenbach on this issue. So, first of all, I would

like to know when the final rule on sunscreen regulations will be issued.

You probably know that the last time this scenario took place was 1999, and there was never a final rule. It sat on the shelf for years and was never fully implemented. I understand this time that there is similar pressure from some manufacturers to indefinitely delay the rule yet again, which is beyond me.

I cannot understand it because there are products that exist. Why, when you go in to buy sunscreen, there currently is a seal of the American Cancer Society, and all it means is they contributed to this effort. It has nothing to do with validating the product.

So I would like you to commit to me today that this will not happen again. It is outrageous that we do not have specific guidelines that are mandated and that the industry should be able to prevent this from becoming final.

Number one, I would like you to do that, and I would like you to commit to implementing a public awareness campaign on sun safety and skin cancer prevention at HHS.

Secretary LEAVITT. Congresswoman, those both seem to be rational requests, and I will respond with respect to information on the rule. I am aware that there are, in fact, campaigns that are done at HHS. Interestingly enough, when I was at EPA we had a campaign on skin cancer related to the rays.

So I will check on both and get back to you. I do not have solutions today. I do not have a response for you today.

Mrs. LOWEY. Well, I would just respectfully suggest that we need you to make it clear that one million deaths from skin cancer is unacceptable and that they have to move and get this rule final. Actually, the rule is a pretty good one compared to 1999. Because of all the additional information, we are making progress.

So I would hope that you would make it very clear that it is unacceptable to let this sit on the shelf while people are dying from skin cancer.

Secretary LEAVITT. I have a scar right across my nose that is a very good reminder of all of that. Thank you.

Mrs. LOWEY. I thank you, and I would appreciate your getting back to me.

AUTISM

Another issue that is astonishing to me, to see the growth of autism. I go to the march every year in my district. There are tens of thousands of people who have autism in their families, and the Federal Government has recently increased its commitment to autism research, diagnosis and tracking.

However, there continues to be a great need for information on effective treatments, interventions, services. I hear from families. They will go from one place to another, all day long, with their youngster to try and get the treatment that they need, and they have difficulty finding trusted sources of information. They are overwhelmed, frankly.

So I would like to know what activities, if any, already underway at HHS are there to assist families with autistic children and is the Department collecting best practices or models created at the State

level when it comes to resources for families with autistic children that can be used at the Federal level?

Secretary LEAVITT. Much of that work is going on at the Centers for Disease Control and Prevention.

About three or four weeks ago, I met with the board that we have assembled of experts around the country in every discipline, representing every perspective, to begin helping us allocate the money that Congress has appropriated for this purpose. I expect we will see a well-coordinated effort flow from their efforts, one that will have been informed by all perspectives as intended in the legislation.

Mrs. LOWEY. I thank you very much, and I am hoping we can get this information out as soon as possible because parents are just desperate.

And, I thank you, Mr. Chairman.

UNIVERSAL HEALTHCARE

Mr. OBEY. Thank you.

Mr. Secretary, at the beginning, you responded to our concerns about the tightness of this budget by saying that the Administration had to take seriously its fiscal responsibilities.

Let me simply say, I hope you will forgive me if I take that response or at least that rationale with a grain of salt because this is an Administration which does not mind providing \$51 billion in tax cuts this year for people who make a million bucks a year or more. They do not mind asking Congress for an extra \$170 billion for the misbegotten War in Iraq. Then they try to reclaim the mantle of fiscal responsibility by cutting \$18 billion out of items on the domestic side of the ledger that we just appropriated last December.

It seems to me that something considerably different than fiscal responsibility is at work here, but we can disagree about that.

Let me talk about the future. In my view, the next President is very likely to pursue passage of a universal healthcare bill. Let's assume that they do, and let's assume that it is based on an essentially private delivery system.

It seems to me that what this Committee needs to be looking at is the question of which programs under our jurisdiction need to be beefed up in order to prepare for the eventuality of universal health coverage. You have to beef up certain aspects of the system, and yet it seems to me that a number of programs that the Administration is cutting are some of the very programs that we will need to, in fact, buttress if we are to meet the new world with universal health coverage.

Yet, you are recommending nurse training reduction, \$46 million; health professions training, \$194 million reduction; National Health Service Corps reduced by \$2 million.

We have already heard a lot of talk about rural health. We have the children's hospital GME program terminated.

We have the NIH budget essentially frozen. We have outcomes research cut by \$9 million.

Am I reading it wrong? Are these programs not programs that are going to have to be expanded in order for us to prepare ourselves for our obligations if we have universal coverage?

Secretary LEAVITT. Mr. Chairman, you and I had a brief conversation, and I have welcomed an opportunity to talk about this.

I think one of the things we can agree on is that there is a widely held aspiration for every American to have health insurance. I think we could also agree that there are two philosophies on how to approach that. One has a different role for government than another.

However, there are some things that I believe are common in those two visions and I believe that is the place where the Committee would be well intended or well directed to begin focusing on.

One of them is in the area of how we can provide more cost and quality information for those who use the system. If, in fact, consumers were provided with that information, I believe we could begin to focus more on value and that many of the inefficiencies that I currently believe are in our system could then begin to be found.

I do not find us to be particularly skilled or accurate as a society in being able to use government as the means of being able to eliminate the areas where there is inefficiency. I do believe if consumers had that information, if we organized our system, whether it was a universal system as you advocate or whether it was a more private system, that we would start to see.

Mr. OBEY. No, no, no. No, no, no. I mean do not equate universal with public. That is a game that is often played when we talk about universal coverage. We are not talking about going to the Canadian system.

We are talking about having everybody covered. You can do that under private approach just as much as you can do it under public approach.

So do not set up that false dichotomy, please.

Secretary LEAVITT. Well, then let me pursue. I am heartened by those words. I can see a vision where quite clearly we could achieve every American having access to an affordable basic plan in a relatively short period of time.

OUTCOMES RESEARCH

Mr. OBEY. But here is my point: Let's skip a lot of these other programs. Let's take something as neutral as outcomes research. We are spending a hell of a lot of money in this country on medicine that is not the right medicine and is not the most effective way to deliver treatment for specific diseases.

Shouldn't we be greatly beefing up outcomes research so if we are facing universal coverage with higher bills, we have ways to reduce those bills?

Secretary LEAVITT. There are three places that I would recommend you look seriously at funding in a way that would make a difference. The first is in electronic medical records because I think at the hub of that, at the hub of effectiveness research you will find the need to collect information on what works and what does not.

The second area would be in measuring and developing measurable quality standards so that we know what we are measuring against when we measure, when we try to find effectiveness.

The third would be making a more rational system of measuring cost where we are beginning to group cost into buckets of care that are meaningful to people both as consumers and as institutions.

If we were to invest in those three things, our capacity to measure effectiveness would be enhanced dramatically. Right now, our capacity to measure effectiveness is impaired by our inability to gather information in a way that can be used in meaningful research.

Mr. OBEY. Okay. Let me move on.

A lot of people in this country are getting increasingly terrified of the prospect of going to a hospital simply because of infection rates. What are you doing to see that the hospitals really get serious about this because, as you know, the performance level varies widely and some hospitals are incredibly careless in that regard?

Secretary LEAVITT. I would go back to the same response. We need to figure out who they are, and we need to expose them. When people understand which hospital in fact they go to that has more risk, they are going to avoid it and the hospital will change.

Mr. OBEY. What are you doing to try to intensify hospitals' attention to the problem?

Secretary LEAVITT. The first thing we are doing is gathering information, and we are publishing and providing information on hospital-borne diseases as fast as we can gather it. People deserve to know which hospital it is.

NIH

Mr. OBEY. Absolutely. Absolutely.

NIH, I have never had anybody come up to me and say, Obey, why don't you get your act together and cut cancer research, and yet over the last two years the NIH budget that you are recommending will have cut roughly 600 grants out of the NIH budget. Why is that a responsible action?

Secretary LEAVITT. Not every grant at NIH shows the promise in the third and fourth and fifth year that it does in the first year.

Mr. OBEY. The success rate for grants has been incredibly diminished over the last decade.

Secretary LEAVITT. We have been working at NIH with the available resources to prioritize those, and we continue to see a steady stream of new investigators.

Mr. OBEY. But you mentioned fiscal responsibility. It seems to me that we have a responsibility to make the investments necessary to reduce future costs. That is a savings too. It just does not happen to occur in this election cycle, but it is nonetheless important.

Secretary LEAVITT. I do not disagree with that.

Mr. OBEY. If you let me give you an example, if you take Lou Gehrig's disease, it is estimated we spend about 43 million bucks nationally on research on that disease. My understanding is you have about 30,000 people in this country who have the problem. If you measure the cost of that on an annual basis, you are probably looking at seven to eight billion dollars.

Now, admittedly, we are far away from finding ways to treat or cure that disease, but you can take any disease you want to name and carry it out. We will be spending a huge amount of money over

the next 10 years to deal with that disease. Doesn't it just make good sense from a fiscal standpoint to be upping significantly our research budget for NIH?

Secretary LEAVITT. Prevention in any form is the best and most efficient way, and you will get no argument from me.

When you look at, however, where the money for research is going, when you look at where the money in States is going from public health, when you look at where money is going away from education, it is because we are paying higher healthcare costs. It all goes back to the need for us to begin to constrain the cost of healthcare.

Now, does that mean adopting Medicare reductions in the growth rate? Well, I mentioned earlier I have a lot of skepticism about that system.

What I do believe can happen is if we begin to create a system where people have access to information and we have comparative effectiveness information, where we have some way for people to know whether they are getting their money's worth, we will see the quality go up and the costs go down.

Mr. OBEY. I think that is just fine.

Secretary LEAVITT. And we can put more money in NIH and cure more diseases. It is the inefficiency of this system that is driving the problem you are mentioning.

Mr. OBEY. With all due respect, let me grant that what you say is partially true. But at the same time, within the budget this year, if you take a look at the budget broadly, the Administration has chosen to conclude that tax cuts for millionaires are more important than added research for medical problems.

I know that is not your decision to make, but I think the question is much more broad than simply inefficiencies in healthcare.

Secretary LEAVITT. But I do think it is related in that the Administration believes that what is vital to having the money to fund any of this is a vibrant economy, and they believe that by having money in the economy and leaving it in the hands of people who use it to generate wealth and enterprise, that it stimulates more jobs and more taxes and, hence, the ability to do it.

LIHEAP

Mr. OBEY. I do not happen to believe in the trickle-down theology, but we can have that debate another time.

LIHEAP, you know we can talk all we want about how that program is targeted between one State and another, but the fact is you have a 22 percent reduction in that program in your budget request. That is really at the 2001 level. You have had energy prices go up by 65 percent during that time.

I have people in my State. It was 38 below zero three weekends ago. Two weekends ago, it was 26 below zero, and I am not talking chill factor. I have people in my district with bills, heating bills, of four and five thousand bucks.

Now there is a moratorium on the fuel company shutting off the supply until April, but then that moratorium expires. Where in hell are these people going to find the help to pay that kind of heating bill if they are making 15 or 18 grand a year?

How can I, with a straight face, say, it is perfectly reasonable to give \$51 billion in tax cuts to millionaires but cut this program by 22 percent?

Secretary LEAVITT. It is probably not just a tax policy issue. It might be an energy policy issue too.

Mr. OBEY. Absolutely. We are paying the price because since Jimmy Carter walked out of the White House no President has been worth a plug nickel in terms of energy policy in either party in my view.

Secretary LEAVITT. I have a lot of opinions. It is not in my portfolio. So, maybe over lunch, we can talk about that. I would very much, Mr. Chairman.

Mr. OBEY. This is so bad, I would rather do it over a drink rather than lunch. [Laughter.]

Secretary LEAVITT. Mr. Chairman, I would, however, like to have some time a very serious conversation.

When we talk about our healthcare system, we really do not have a healthcare system. What we have is a big, unwieldy healthcare sector. There is nothing in it that would approximate a system, and we have to get serious about creating an economic system out of healthcare.

Mr. OBEY. I absolutely agree with that, and that is why I think that Medicare reform has to come in the context of overall healthcare reform in the Country.

Secretary LEAVITT. Amen to that and both of them need to begin to be more sensitive to real value.

The budget I presented to you today is a pro forma based on a spreadsheet. The system itself does not allow us to start talking about reform. This is not reform. It is a budget. We have to have a serious conversation about reform.

Mr. OBEY. I understand, but again that is above my pay grade and yours.

Secretary LEAVITT. It is certainly in our avenue of interest.

Mr. OBEY. Our responsibility is for the moment to deal this year with this set of programs in the Subcommittee, and so let me simply close by saying what I said in the beginning.

We are not going to buy this kind of cuts in the low income heating assistance program. We are not going to buy the elimination of vocational education. We are not going to buy the elimination of the SEOG student aid program. We are not going to buy the kind of deep reductions in health professions training that this budget contains, and I honestly do not think that the Administration expects us to.

So I hope that recognizing that we can sit down with the Administration and work out a reasonable compromise between where you want to go with your budget and where we think we ought to go.

Secretary LEAVITT. Thank you.

Mr. OBEY. It would be nice if we did something besides shake our fingers at each other for the next eight months. It would be nice if we could actually get something done.

Thank you. We appreciate your coming.

CONTRACTS

Mr. Obey: Please update the table on page 92 of Part 6 of the Hearings on the FY 2008 President's request to include annual HHS contract obligations from fiscal years 2000 through 2007 by operating division, and for the department as a whole. In addition, please include an explanation for the growth in reliance on outside contractors.

Secretary Leavitt: We have updated the table on HHS Contract Obligations to include FY 2007 by Operating Division and by HHS as a whole.

HHS CONTRACT OBLIGATIONS, FY2000 - FY2007										
(\$ in millions)										
	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	Change FY2000 - FY2007	
									Dollars	Percent
AHRQ	65.5	82.2	96.1	102.5	121.7	153.8	163.4	186.8	121.3	185%
CDC	433.3	637.5	1,089.2	758.5	1,520.6	1,861.1	3,127.0	4,101.8	3,668.5	847%
CMS	422.0	559.9	599.8	742.6	1,066.3	1,342.4	1,266.3	1,752.6	1,330.6	315%
FDA	198.0	198.3	267.0	234.7	280.0	315.6	311.3	375.6	177.6	90%
HRSA	84.1	117.7	134.5	163.1	196.3	141.4	129.7	158.3	74.2	88%
IHS	656.5	675.3	709.3	658.3	1,011.1	944.4	888.4	613.4	-43.1	-7%
NIH	1,852.1	1,943.6	2,695.6	3,040.0	4,068.4	4,049.9	3,948.8	4,106.1	2,254.0	122%
ASPR				5.1	0.0	920.8	2,100.0	2,027.8	2,027.8	N/A
PSC	654.8	525.1	605.3	550.4	642.6	699.9	969.6	857.4	202.6	31%
SAMHSA	160.3	230.6	188.2	257.4	301.8	325.3	295.0	316.3	156.0	97%
HHS Total	\$4,526.6	\$4,970.2	\$6,385.0	\$6,512.6	\$9,208.8	\$10,754.6	\$13,199.4	\$14,496.1	\$9,969.5	220%
FY 2007 data are current as of March 19, 2008. FY2000 to FY2006 data were current as of April 25, 2007.										
*Totals may not add due to rounding.										

Change from FY 2006 to FY 2007: The Department-wide increase in contract obligations between FY 2006 and FY 2007 was concentrated in two OPDIVs. CMS and CDC increased their contract obligations from \$1.3B to \$1.8B and \$3.1B to \$4.1B, respectively.

The original (fee-for-service) Medicare program has been administered by private contractors since its inception. CMS's increased obligations reflect the change in status of Medicare claims processing agreements. Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the claims processing agreements were statutorily directed by Title XVIII of the Social Security Act and exempt from the Federal Acquisition Regulations (FAR). As they were exempt from the FAR, those contracts were excluded from the HHS and government-wide contract databases. The MMA authorized Medicare contracting reform, which is converting those antiquated claims processing agreements into new, competitive Medicare Administrative Contracts (MACs) that are subject to FAR requirements. As the existing agreements expire, they are being replaced with competitive MAC contracts that are subject to the FAR and thus included in the databases. In addition, the MMA created a new prescription drug benefit and significantly expanded the Medicare managed care program, called Medicare

Advantage. CMS's increased obligations therefore also reflect Agency contracts such as information technology enhancements associated with preparing for and supporting the new prescription drug benefit and expanded Medicare Advantage program.

CDC's \$1 billion increase from FY 06 to FY 07 is largely due to the growth in vaccine programs for low-income children. Other major health initiatives at CDC include contracts in support of HHS's enhanced Pandemic Flu Preparedness and critical contracts for emergency operations and support – accounting for about \$130 million of the increase. And finally, the timing of buildings and facilities contracts accounts for \$246 million of the change.

Increases since FY 2000:

In FY 2000, HHS spent \$4.5 billion on outside contractors. In subsequent years, as the Department experienced substantial growth in many programs, the use of contracts grew with program growth. In addition, HHS converted some activities to contracts to improve management and oversight. HHS also entered new fields such as bioterrorism/ flu preparedness, which required the use of contracts for vaccines, antivirals, and other countermeasures. Specifically, many of those contracts fall in the realm of the recently-created office of the Assistant Secretary for Preparedness and Response (ASPR), which is an office and mission that did not exist before FY 2004.¹

Three OPDIVs—CDC, NIH, and ASPR—increased their contractual obligations by more than \$2 billion each from FY 2000 to FY 2007. In FY 2006 and FY 2007, CDC and ASPR (BioShield) obligated large amounts for vaccines, vaccine research, anthrax antitoxin, and research into antitoxins. NIH's obligations were static at \$4B for FY 2004, FY 2005, and FY 2006, following a doubling in NIH's obligations from FY 2000 to FY 2004. The NIH increase from FY 2000 to FY 2004 reflects increased across-the-board funding for research into the causes and cures for disease. And finally, ASPR grew significantly between FY 2005 and FY 2006, reflecting BioShield and pandemic flu preparedness, and was relatively stable in FY 2007.

CDC vaccine grants shifted to contracts: One large increase in contract obligations was due to CDC's transition from grants to contracts for vaccine purchase in the VFC and Section 317 programs in FY 2006, with VFC continuing to grow in FY 2007. In late 2003, CDC established a team to conduct a comprehensive review of the vaccine management activities at the federal, state, and local levels, and to identify opportunities to improve efficiency, accountability, and our ability to respond to public health crises. One of the priority areas identified was funds management.

Awarding vaccine purchase funds directly to grantees through grants to the 63 immunization programs required that, before the beginning of each grant year, CDC and the grantee correctly estimate the amount that a grantee would need to spend for vaccine purchases for the entire year. Since precision in these estimates was very difficult, when a grantee's needs increased during a grant year, funds were de-obligated from a grantee that was not going to use all of its award and awarded to the grantee with the increased need. This process took several weeks and sometimes resulted in grantees having no vaccine funds available for several weeks, and in

¹ The Pandemic and All-Hazards Preparedness Act, P.L. 109-47, changed the name of the former Office of Public Health and Emergency Preparedness (OPHEP) to the Office of the Assistant Secretary for Preparedness and Response (ASPR). They initiated contract activities in FY 2003.

some instances running out of vaccine. By obligating vaccine purchase funds directly to the vaccine manufacturer contracts, CDC is able to adjust grantee budgets immediately.

The funds obligated to the vaccine manufacturers are monitored on an ongoing basis. The funds are obligated to these contracts quarterly, assuring that funds are available for grantee vaccine purchases. In addition, by retaining the funds centrally at CDC and obligating them directly to the vaccine manufacturer contracts, CDC is able to centralize vaccine distribution.

The amount of FY 2007 vaccine funding that is eligible to be obligated against the manufacturers' contracts is almost \$2.5 billion for VFC and \$254 million for 317. Under CDC's old vaccine funds management model, these funds would have been obligated to 63 vaccine grantees.

Other increases: Other areas of increase include implementation of an aggressive program to procure vaccines and antiviral drugs as countermeasures against anthrax and other bioterrorism threats as well as vaccine research and procurement of antiviral drugs for pandemic flu such as Tamiflu and Relenza (see ASPR on above table figure); substantial increases in health research at NIH, prescription drug coverage, and the growth in Medicare claims and the contractor costs of processing these claims.

Mr. Obey: Please update the table on page 95 of Part 6 of the Hearings on the FY 2008 President's request to include the number, dollar amount, and percentage of the total for all contracts awarded noncompetitively for each of fiscal years 2000 through 2007. In addition, please include an explanation for the growth in noncompetitive contracts.

Secretary Leavitt: We have updated the table on Competition in HHS Contracts to include FY 2007. The majority of contracts awarded by HHS have been competed. In FY 2007, HHS awarded 19 percent of its contract dollars noncompetitively.

Competition in HHS Contracts

(\$ in millions)

	Actions			Obligations (\$)		
	Total	NonComp	% NonComp	Total	NonComp	% NonComp
FY2000	218,553	93,978	43%	4,526.6	578.2	12.8%
FY2001	230,504	53,016	23%	4,970.2	677.8	13.6%
FY2002	190,948	40,099	21%	6,385.0	978.1	15.3%
FY2003	223,865	38,057	17%	6,512.6	902.0	13.9%
FY2004	200,320	30,048	15%	9,208.8	1,211.1	13.2%
FY2005	71,069	17,596	25%	10,754.6	1,499.1	13.9%
FY2006	72,583	20,936	29%	13,199.4	1,954.6	14.8%
FY2007	65,637	19,870	30%	14,496.1	2,759.7	19.0%

FY 2007 data are current as of March 19, 2008. FY2000 to FY2006 data were current as of April 25, 2007.

HHS has pursued an aggressive program to procure vaccines and antiviral drugs as countermeasures against anthrax, other bioterrorism threats and pandemic influenza. In some cases, there is only one manufacturer of critical countermeasures. For example, Fleming, a small business, is the only FDA-approved manufacturer of a liquid pediatric formulation of potassium iodide. The most significant examples of sole source countermeasures include Anthrax Vaccine Adsorbed (AVA) and influenza antivirals. Currently, there is only one manufacturer which can supply FDA-licensed anthrax vaccine: Emergent BioDefense Operations of Lansing, Michigan. In September 2007, HHS awarded a sole source contract for delivery to the Strategic National Stockpile (SNS). To foster future competitive sources for the Government's anthrax vaccine purchases, in February 2008, BARDA issued a competitive solicitation to develop and deliver a next-generation anthrax vaccine using recombinant protective antigen (rPA). In addition, the antiviral drugs, oseltamavir (Tamiflu) and zanamavir (Relenza), are each made by a single manufacturer, Roche Pharmaceuticals and Glaxo Smith Kline, respectively.

Other non-competitive BARDA acquisitions included a follow-on effort to maintain Government property used by Cangene in the development and delivery of an antitoxin to treat up to seven botulism types to the SNS.

For H5N1 bulk influenza vaccine, the projected U.S. requirement within six months of a pandemic far exceeds the manufacturing capacity. To stockpile vaccine, BARDA has contracts with three companies that have an FDA-licensed seasonal influenza vaccine. BARDA placed orders with these companies in 2007 for the H5N1 bulk vaccine to be produced when the contractor was not producing seasonal vaccine.

In FY 2005 and FY 2006 HHS awarded contracts to five companies to develop cell-based methods of producing influenza vaccine. If successful, these contracts will increase manufacturing capacity and promote competition among an increased number of suppliers of pandemic vaccine.

In FY 2007 Congress enacted improvements relating to Project BioShield, including authorization of advanced research and development (ARD) funding to develop medical countermeasures. These ARD funds may enable BARDA to increase the number of potential competitors for manufacturing vaccines and other countermeasures, encouraging development of competing products.

CMS' Professional IT Services (PITS) contracts expired in FY 2006, but the replacement Enterprise Systems Development (ESD) contracts, which were structured as competitive multiple-award contracts, proved more difficult and time-consuming to award than originally projected. Consequently, CMS' ESD contracts were not available in FY 2007 to meet IT support requirements. CMS was required to award multiple one-year IT support contracts to "bridge" the gap between the expiration of the PITS contracts and award of the new ESD contracts. Among these bridge contracts were \$27 million and \$14.5 million IT contracts to CSC, \$11 million and \$8 million IT contracts to AMS, and a \$25 million IT contract to Siebel Software. Without these noncompetitive bridge contracts, CMS' noncompetitive percentage would have been less than 14 percent.

Mr. Obey: Please update the table on Page 96 of Part 6 of the Hearings on the FY 2008 President's request to include the total noncompetitive contract obligations for each operating division within the department and the share of all such obligations for the department for each of fiscal years 2000 through 2007.

Secretary Leavitt: We have updated the table on HHS Total vs. Noncompetitive Contract Obligations by Fiscal Year and Operating Division to include FY 2007.

**HHS Total vs. Noncompetitive Contract Obligations
by Fiscal Year and Operating Division
(\$ in millions*)**

OPDIV	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
AHRQ								
Total obligations	65.5	82.2	96.1	102.5	121.7	153.8	163.4	186.8
Noncompetitive	0.6	1.9	0.3	1.8	5.4	6.2	16.3	8.0
Percent of total	0.9%	2.4%	0.3%	1.7%	4.4%	4.0%	10.0%	4.3%
CDC								
Total obligations	433.3	637.5	1,089.2	758.5	1,520.6	1,861.1	3,127.0	4,101.8
Noncompetitive	12.0	92.1	146.2	102.1	175.8	320.6	274.5	308.8
Percent of total	2.8%	14.4%	13.4%	13.5%	11.6%	17.2%	8.8%	7.5%
CMS								
Total obligations	422.0	559.9	599.8	742.6	1,066.3	1,342.4	1,266.3	1,752.6
Noncompetitive	62.9	95.9	82.6	90.6	181.3	266.3	182.7	318.4
Percent of total	14.9%	17.1%	13.8%	16.1%	17.0%	19.8%	14.4%	18.2%
FDA								
Total obligations	198.0	198.3	267.0	234.7	280.0	315.6	311.3	375.6
Noncompetitive	6.9	7.9	6.8	13.1	32.3	47.2	89.6	97.5
Percent of total	3.5%	4.0%	2.5%	5.6%	11.5%	15.0%	28.8%	26.0%
HRSA								
Total obligations	84.1	117.7	134.5	163.1	196.3	141.4	129.7	158.3
Noncompetitive	16.1	19.0	28.0	25.9	23.4	21.2	16.4	10.7
Percent of total	19.1%	16.1%	20.8%	15.9%	11.9%	15.0%	12.6%	6.8%
IHS								
Total obligations	656.5	675.3	709.3	658.3	1,011.1	944.4	888.4	613.4
Noncompetitive	244.2	221.7	229.3	249.2	209.9	249.4	205.8	180.7
Percent of total	37.2%	32.8%	32.3%	37.9%	20.8%	26.4%	23.2%	29.5%
NIH								
Total obligations	1,852.1	1,943.6	2,695.6	3,040.0	4,068.4	4,049.9	3,948.8	4,106.1
Noncompetitive	195.1	196.0	439.7	355.8	454.6	455.1	469.2	563.4
Percent of total	10.5%	10.1%	16.3%	11.7%	11.2%	11.2%	11.9%	13.7%
ASPR								
Total obligations				5.1	0.0	920.8	2,100.0	2,027.8
Noncompetitive				0.0	0.0	5.7	598.5	1,123.4
Percent of total				0.0%		0.6%	28.5%	55.4%
PSC								
Total obligations	654.8	525.1	605.3	550.4	642.6	699.9	969.6	857.4
Noncompetitive	39.2	37.9	41.6	51.7	90.6	79.1	80.4	127.6
Percent of total	6.0%	7.2%	6.9%	9.4%	14.1%	11.3%	8.3%	14.9%
SAMHSA								
Total obligations	160.3	230.6	188.2	257.4	301.8	325.3	295.0	316.3
Noncompetitive	1.2	5.3	3.6	12.0	37.8	48.4	21.3	21.2
Percent of total	0.7%	2.3%	1.9%	4.7%	12.5%	14.9%	7.2%	6.7%
HHS Total								
Total obligations	4,526.6	4,970.2	6,385.0	6,512.6	9,208.8	10,754.6	13,199.4	14,496.1
Noncompetitive	578.2	677.8	978.1	902.0	1,211.1	1,499.1	1,954.6	2,759.7
Percent of total	12.8%	13.6%	15.3%	13.9%	13.2%	13.9%	14.8%	19.0%

FY 2007 data are current as of March 19, 2008. FY2000 to FY2006 data were current as of April 25, 2007.

* Totals may not add due to rounding.

Mr. Obey: Please update the tables on Page 97 of Part 6 of the Hearings on the FY 2008 President's request showing the number of contract actions and total awards for contracts issues with less than full and open competition by operating division, and for the department as a whole, in each of fiscal years 2005, 2006, and 2007.

Secretary Leavitt: Summaries of Noncompetitive Awards follow. FY2000 to FY2006 data were current as of April 25, 2007. FY 2007 data are current as of March 19, 2008.

**HHS Noncompetitive Awards
FY2005
(\$ in millions)**

Op Div	Total Actions	Total Award
AHRQ	35	6.2
CDC	2,458	320.5
CMS	680	266.3
FDA	865	47.2
HRSA	1,258	21.2
IHS	5,589	253.7
NIH	5,117	454.9
ASPR	1	5.7
PSC	1,531	79.1
SAMHSA	61	48.4
HHS Total	17,595	\$1,503.1

**HHS Noncompetitive Awards
FY2006
(\$ in millions)**

Op Div	Total Actions	Total Award
AHRQ	62	16.3
CDC	3,629	274.4
CMS	724	178.9
FDA	2,545	89.4
HRSA	1,105	16.4
IHS	5,761	205.2
NIH	5,383	468.2
ASPR	10	598.5
PSC	1,648	80.4
SAMHSA	67	21.3
DHHS Total	20,934	\$1,948.9

**HHS Noncompetitive Awards
FY2007**
(\$ in millions)

Op Div	Total Actions	Total Award
AHRQ	62	8.0
CDC	3,374	308.8
CMS	716	318.4
FDA	3,515	97.5
HRSA	712	10.7
IHS	5,066	180.7
NIH	4,834	563.4
ASPR	20	1,123.4
PSC	1,545	127.6
SAMHSA	45	21.2
DHHS Total	19,889	\$2,759.7

Mr. Obey: Please provide the number of contract FTE for each operating division and the department as a whole for fiscal years 2005, 2006, and 2007.

Secretary Leavitt: We did not collect this information in fiscal years 2005 or 2006. Our initial figures for contract employees at HHS come from March, 2007. Through the use of the Department's HSPD-12 program that tracks the number of badges issued to contractors in the Agencies and Offices of the Department, our best estimate for the current number of contract employees at HHS is 28,010. This count includes many categories of contractors, such as scientific fellows, Medicare claims processors, construction workers, security personnel, repair and maintenance workers, housekeeping staff, etc. – in addition to contractors that assist professional staff. Some of these contractors are full time; some are part-time; but we currently do not have information to distinguish among them.

However, we are able to provide three separate estimates of our department's use of contractors over the past twelve months. The following table includes estimates from March, 2007; September, 2007; and March, 2008. Again, the contractor numbers are provided from the HSPD-12 program which counts badges provided to contractors – not the precise number of contractors at each agency. The estimates suggest a slight decrease in the department's use of contractors over the past twelve months. This downward trend is largely due to a decrease in construction projects. For instance, CDC reduced their employment of contractors after the completion of construction efforts on Building 21 in Atlanta, Georgia.

Contractors by HHS Operating Division

Op Div	March 2007	September 2007	March 2008
ACF	341	692	692
AHRQ	105	394	194
AOA	14	14	14
CDC	9,715	6,689	6,802
CMS	2,502	2,452	2,452
FDA*	5,000	5,000	5,000
HRSA	688	725	727
IHS	695	695	725
NIH	11,089	11,089	10,151
OS	2,206	1,714	1,053
SAMHSA	240	175	200
Total HHS	32,595	29,639	28,010

* Estimate

GRANTS

Mr. Obey: Please provide the number and amount of all noncompetitive grants awarded by each operating division, and the percentage share of all such grants for the department as a whole, in each of fiscal years 2005, 2006 and 2007, excluding any Congressional earmarks. Please providing a listing of all such grants awarded in fiscal year 2007.

Secretary Leavitt: Before discussing the requested dollar figures and percentages of our grants, I would like to clarify some information on HHS grants. HHS grants policy requires objective review for all grant applications unless the Congress has specified the grantees and the amount of the grant. We do this as part of our effort to ensure that American taxpayers receive as much benefit as possible from the resources entrusted to the Department.

Of grants funded through discretionary appropriations, the majority are allocated either by the basis of statutory formula or on the results of outside peer/objective review.

Smaller allocations are based on other criteria. For this exercise, I have compiled a list of grants that fit into one of the following categories:

- Unsolicited Grants
- Sole Source or Limited Source Grants
- Competitive Grants, with only Internal Review

It is important to note that CMS allocated \$370 million in stabilization grants in FY 2007 to assist in post-Katrina rebuilding along the Gulf Coast. If you subtract those grants from the Department's overall total, grants falling into the aforementioned three categories continue to represent only one-tenth of one percent of the Department's overall grant funding.

The attached tables provide greater detail, and includes data by operating agency.

**Grant Funding
by OPDIV / STAFFDIV**
(Total, \$ in thousands)

OPDIV	FY 2005			FY 2006			FY 2007		
	Total	Selected*	%	Total	Selected*	%	Total	Selected*	%
ACF	\$44,506,415	\$15,936	0.0%	\$46,293,472	\$10,818	0.0%	\$45,238,835	\$3,838	0.0%
AHRQ	\$102,572	\$8,312	8.1%	\$104,685	\$5,284	5.0%	\$88,425	\$11,044	12.5%
AoA	\$1,381,222	\$866	0.1%	\$1,333,486	\$365	0.0%	\$1,355,120	\$1,312	0.1%
CDC	\$5,070,343	\$87,521	1.7%	\$4,132,618	\$161,341	3.9%	\$4,037,343	\$192,654	4.8%
CMS	\$162,058,069	\$200	0.0%	\$145,304,400	\$156	0.0%	\$192,058,435	\$370,000	0.2%
FDA	\$26,263	\$11,321	43.1%	\$27,424	\$13,303	48.5%	\$30,381	\$16,480	54.2%
HRSA	\$6,162,099	\$7,555	0.1%	\$5,445,381	\$4,497	0.1%	\$5,281,559	\$200	0.0%
IHS	\$168,833	\$24,842	14.7%	\$170,529	\$29,272	17.2%	\$171,459	\$30,122	17.6%
NIH	\$17,361,226	\$4,553	0.0%	\$21,000,241	\$3,858	0.0%	\$21,263,484	\$2,971	0.0%
OS	\$496,047	\$0	0.0%	\$401,777	\$47,577	11.8%	\$862,475	\$295	0.0%
SAMHSA	\$2,991,749	\$11,000	0.4%	\$2,986,827	\$290	0.0%	\$2,944,147	\$1,728	0.1%
HHS Total =	\$241,303,675	\$172,107	0.1%	\$228,171,021	\$276,762	0.1%	\$273,331,661	\$630,645	0.2%
(Minus Katrina Spending)							\$273,331,661	\$260,645	0.1%

* "Selected" column includes unsolicited grants, sole source or limited source grants, and competitive grants with only internal review

**Number of Grants
by OPDIV / STAFFDIV
(Total, #)**

OPDIV	FY 2005			FY2006			FY 2007		
	Total	Selected*	%	Total	Selected*	%	Total	Selected*	%
ACF	7,745	97	1.3%	8,280	67	0.8%	7,899	39	0.5%
AHRQ	356	56	15.7%	378	50	13.2%	339	38	11.2%
AOA	1,168	8	0.7%	1,093	1	0.1%	1,086	3	0.3%
CDC	3,409	104	3.1%	3,142	320	10.2%	3,167	242	7.6%
CMS	511	1	0.2%	483	1	0.2%	571	5	0.9%
FDA	124	77	62.1%	111	66	59.5%	108	52	48.1%
HRSA	6,928	40	0.6%	5,451	8	0.1%	6,119	1	0.0%
IHS	898	73	8.1%	662	20	3.0%	600	6	1.0%
NIH	49,266	227	0.5%	53,285	217	0.4%	53,480	188	0.4%
OS	573	0	0.0%	496	16	3.2%	553	2	0.4%
SAMHSA	2,319	1	0.0%	2,180	20	0.9%	2,164	18	0.8%
HHS Total =	73,302	684	0.9%	75,561	802	1.1%	76,086	596	0.8%
(Minus Katrina Spending)							76086	591	0.8%

* "Selected" column includes unsolicited grants, sole source or limited source grants, and competitive grants with only internal review

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FY 2005 Non-Competitive Grants						
OPDIV	Program Title	Grant Title	Grant Award #	Grantee Name	Unsolicited (Y/N)	Sole Source / Limited Competition (Y/N)
Administration for Children and Families (ACF)						
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0010	Adoption Exchange Association	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0017	University of Southern Maine	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0012	Research Foundation of CUNY	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0011	Spaulding for Children	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0015	Action for Child Protection, Inc.	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0013	American Bar Assn Fund for Justice and Education	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90W0014	University of Oklahoma	N	SS-Y
ACF	ACYF/CB	Urgent Award - Hurricane Katrina Relief	90XW0016	Child Welfare League of America	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0019	Mid-Atlantic Network of Youth & Family Services	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0018	Youth Network Council	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0016	Southeastern Network of Youth & Family Services	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0014	Empire State Coalition of Youth & Family Services	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0031	Northwest Network of Runaway & Youth Services	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0017	Western States Youth Services Network	N	SS-Y
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0021	New England Network for Child, Youth & Family Services.	N	SS-Y

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ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0007	Southwest Network for Child, Youth & Family Services	N	SS-Y	\$100,000
ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0015	Mountain Plains Network for Youth	N	SS-Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0015	State of Nebraska Health & Human Services	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0016	University of Kentucky Research Foundation	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0017	State of Oregon	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0018	New York Office of Children & Family Services	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0019	State of Louisiana	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0020	Iowa Department of Human Rights Criminal & Juvenile Justice	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0021	Commonwealth of Massachusetts	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0022	Illinois Department of Human Services	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Youth Development State Collaborations	90YS0023	Governor's Office for Children Youth & Families	N	SS Program Expansion Supplement - Y	\$100,000
ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0024	Mississippi Gulf Coast YMCA	N	SS-Y	\$99,553
ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0030	Big Brothers Big Sisters of Heart of GA	N	SS-Y	\$95,000
ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0020	Big Brothers Big Sisters of Mississippi	N	SS-Y	\$95,000
ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0026	America on Track	N	SS-Y	\$95,000
ACF	ACYE/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0011	Volunteer in Prevention Probation and Prisons	N	SS-Y	\$95,000

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ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0027	Big Brothers Big Sisters of Boone County	N	SS-Y	\$95,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0025	Big Brothers Big Sisters of Kentucky	N	SS-Y	\$95,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0010	Big Brothers Big Sisters of Nevada	N	SS-Y	\$95,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0032	Big Brothers Big Sisters of Eastern Missouri	N	SS-Y	\$95,000
ACF	ACYF/FYSB	Basic Centers	09CY5123	YMCA of San Diego	N	SS Program Expansion Supplement - Y	\$95,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0029	Big Buddy Program	N	SS-Y	\$90,000
ACF	ACYF/FYSB	Basic Centers	06CY0828	Youth Services of Tulsa	N	SS Program Expansion Supplement - Y	\$70,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0009	MINK Network of Runaway & Homeless Youth Services	N	SS-Y	\$65,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0012	Centerforce, Inc.	N	SS-Y	\$63,170
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0034	Families Under Urban and Social Attacks	N	SS-Y	\$56,250
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0023	State of Alabama Child Abuse and Neglect Prevention Board	N	SS-Y	\$50,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0008	YMCA of Greater Louisville, KY	N	SS-Y	\$50,000
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0033	Pima Prevention Partnership	N	SS-Y	\$33,936
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0028	Family and Children's Agency, Inc.	N	SS-Y	\$21,350
ACF	ACYF/FYSB	Urgent Award - Hurricane Katrina Relief	90XF0013	Rhode Islanders Sponsoring Education	N	SS-Y	\$13,900
ACF	Administration on Developmental Disabilities	Family Assistance	90DF0113	ASK Resource Center	N	LC-Y	\$100,000
ACF	Administration on Developmental Disabilities	Family Assistance	90DF0115	State of Alabama	N	LC-Y	\$100,000
ACF	Administration on Developmental Disabilities	Family Assistance	90DF0112	Support for Families of Children with Disabilities	N	LC-Y	\$100,000
ACF	Administration on Developmental Disabilities	Family Assistance	90DF0114	Mental Retardation Program of Puerto Rico	N	LC-Y	\$50,000
ACF	ANA	Urgent Award	90NA7785	Red Lake Band of Chippewa Indians	N	SS-Y	\$311,400

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ACF	ANA	Social and Economic Development	90NA7656	Standing Rock Sioux Tribe	N	SS Program Expansion Supplement - Y	\$142,320
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1730	University of Kentucky Research Foundation	N	LC-Y	\$900,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1746	University of North Carolina at Chapel Hill	N	LC-Y	\$500,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1749	University of Maryland, Baltimore	N	LC-Y	\$250,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1744	Washington State Department of Social and Health Service	N	LC-Y	\$249,989
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1745	University of North Carolina at Chapel Hill	N	LC-Y	\$249,869
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1748	San Diego State University Research Foundation	N	LC-Y	\$249,216
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1741	Lao Family Community Development, Inc.	N	LC-Y	\$150,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1742	Texas Health and Human Services Commission	N	LC-Y	\$150,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1736	The Osborne Association	N	LC-Y	\$150,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1740	Rockford MELD	N	LC-Y	\$149,937
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1735	Red Cliff Band of Lake Superior Chippewa	N	LC-Y	\$149,819
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1734	Lifestarts Youth & Family Services	N	LC-Y	\$148,690
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1738	Starkville School District	N	LC-Y	\$146,213
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1733	Mississippi Band of Choctaw Indians	N	LC-Y	\$143,000
ACF	Children's Bureau	Child Abuse and Neglect Discretionary Grants	90CA1731	Yakima Valley Farm Workers Clinic	N	LC-Y	\$141,274
ACF	OCSE	Rural Facilities	90EF0058	Rural Community Assistance Program, Inc.	N	SS-Y	\$500,000
ACF	OCSE	SIP	90FI0078	Monterey County, CA, Department of Child Support Services			\$200,000
ACF	OCSE	SIP	90FI0079	Episcopal Social Services of Wichita, KS			\$193,600

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ACF	OCSE	SIP	90F0082	National Council of Juvenile and Family Court Judges, NY			\$150,000
ACF	OCSE	SIP	90F0081	MI 3rd Judicial Circuit Court			\$145,950
ACF	OCSE	Section 1115	90FD0104	UT Department of Human Services			\$120,000
ACF	OCSE	Section 1115	90FD0112	AZ Child Support Enforcement			\$120,000
ACF	OCSE	Section 1115	90FD0106	VT Agency of Human Services			\$118,607
ACF	OCSE	Section 1115	90FD0111	CO Department of Human Services			\$114,741
ACF	OCSE	Section 1115	90FD0105	WI Department of Workforce Development			\$108,400
ACF	OCSE	Section 1115	90FD0107	WA State Department Social and Health Services			\$108,400
ACF	OCSE	Section 1115	90FD0110	HI Child Support Enforcement Agency			\$108,400
ACF	OCSE	Section 1115	90FD0113	TX Office of Attorney General			\$108,112
ACF	OCSE	Section 1115	90FD0109	MD Department of Human Resources			\$105,562
ACF	OCSE	SIP	90F0070	The Fathers' Support Center, St. Louis, MO			\$100,000
ACF	OCSE	SIP	90F0072	TX Office of the Attorney General			\$100,000
ACF	OCSE	SIP	90F0073	Center for Policy Research, Denver, CO			\$100,000
ACF	OCSE	SIP	90F0074	Georgia State University			\$100,000
ACF	OCSE	SIP	90F0076	Families Under Urban and Social Attack, TX			\$100,000
ACF	OCSE	SIP	90F0077	AL Child Abuse and Neglect Prevention Board, The Children's Trust Fund			\$100,000
ACF	OCSE	SIP	90F0075	MI Department of Community Health			\$99,792
ACF	OCSE	SIP	90F0069	South Baton Rouge Christian Children's Foundation of LA			\$99,703
ACF	OCSE	SIP	90F0071	Michigan State University			\$98,364
ACF	OCSE	Section 1115	90FD0108	TN Department of Human Services			\$82,853
ACF	ORR	Non-Competitive Award	90XR0010	World Vision	N	SS-Y	\$497,983
ACF	ORR	Non-Competitive Award	90XR0011	World Vision	N	SS-Y	\$497,983

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Administration for Healthcare Research and Quality (AHRQ)						
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	HS016128-01	SARAH BUSH LINCOLN HEALTH CENTER	N	Y	\$500,000
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	HS016131-01	TAHLEQUAH CITY HOSPITAL	N	Y	\$500,000
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	HS016151-01	FRANKLIN FOUNDATION HOSPITAL	N	Y	\$500,000
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	HS016162-01	WEIS CENTER FOR RESEARCH-GEISINGER CLINC	N	Y	\$500,000

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AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Creating Online NICU Networks to Educate, Consult & Team	HS016147-01	UNIVERSITY OF SOUTHERN MISSISSIPPI	N	Y	\$499,999
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Critical Access Hospital Partnership HIT Implementation	HS016152-01	UPPER PENINSULA HEALTH CARE NETWORK	N	Y	\$498,506
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	El Dorado County Safety Net Technology Project / ACCESS*	HS016129-01	MARSHALL MEDICAL	N	Y	\$497,395
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Metro DC Health Information Exchange (MedHIX)	HS016130-01	PRIMARY CARE COALITION/MONTGOMERY COUNTY	N	Y	\$494,760

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AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Cutting Edge Technology--Health Quality in Kern County	HS016146-01	TEHACHAPI HOSPITAL	N	Y	\$492,043
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	A Community-shared Clinical Abstract to Improve Care	HS016155-01	FAIRVIEW HEALTH SERVICES	N	Y	\$485,887
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Holomua Project Improving Transitional Care in Hawaii	HS016160-01	HAWAII PRIMARY CARE ASSOCIATION	N	Y	\$476,200
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	EHR Implementation for Continuum Care in Rural Iowa	HS016156-01	HANCOCK COUNTY HEALTH SERVICES	N	Y	\$475,351

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AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	The Chronic Care Technology Project	HS016154-01	AROSTOOK MEDICAL CENTER	N	Y	\$436,553
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Improving Quality Care for Children with Special Needs	HS016133-01	UNIVERSITY OF TENNESSEE KNOXVILLE	N	Y	\$365,497
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Improving Rural Healthcare with Integration Solutions	HS016142-01	MT. ASCUTNEY HOSPITAL AND HEALTH CENTER	N	Y	\$269,462
AHRQ	LIMITED COMPETITION FOR AHRQ TRANSFORMING HEALTHCARE QUALITY THROUGH INFORMATION TECHNOLOGY ? IMPLEMENTATION GRANTS	Health Information Exchange: A Frontier Model	HS016143-01	CHADRON COMMUNITY HOSPITAL	N	Y	\$170,402
AHRQ	NIH PREDOCTORAL FELLOWSHIP AWARD FOR MINORITY STUDENTS	Minority Predoctoral Fellowship Program	HS016164-01	HARVARD UNIVERSITY (MEDICAL SCHOOL)	N	Y	\$33,524

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AHRQ	NIH SUPPORT FOR CONFERENCES AND SCIENTIFIC MEETINGS	METS: Preventing Patient Crises: Protecting in Crisis	HS015757-01	UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$25,000
AHRQ	RUTH L KIRSCHSTEIN NATIONAL RESEARCH SERVICE AWARD FOR INDIVIDUAL POSTDOCTORAL FELLOWS	Disparities in Surgical Outcomes and Hospital Volume	HS015773-01	SLOAN-KETTERING INSTITUTE FOR CANCER RES	N	Y	\$48,296
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Health Services Research Roundtable	HS015708-01	ACADEMY HEALTH			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Building Bridges XI: Applying Evidence-based Solutions	HS015761-01	AMERICA'S HEALTH INSURANCE PLANS			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Lean Training for Healthcare System Redesign	HS016278-01	DENVER HEALTH AND HOSPITAL AUTHORITY			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	National Asthma Disparities Conference	HS015762-01	NORTHWESTERN UNIVERSITY			\$49,980
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Model--Adopting New Technology from National Registries	HS016203-01	NATIONAL COMMITTEE FOR QUALITY ASSURANCE			\$49,714
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Advancing the Agenda for Home Health Care Quality	HS015705-01	VISITING NURSE SERVICE OF NEW YORK			\$41,500
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	HMO Research Network 11th Annual National Conference	HS015956-01	LOVELACE CLINIC FOUNDATION			\$40,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Quality based Physician incentive programs	HS015959-01	BLUE CROSS/BLUE SHIELD FDN ON HLTH CARE			\$39,350
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Benchmarking Physician Performance: Current Practice & Research Needs	HS016277-01	NATIONAL COMMITTEE FOR QUALITY ASSURANCE			\$38,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Improving Hospital and Laboratory Safety	HS016270-01	UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$31,293
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Health Services Research Competencies	HS016070-01	JOHNS HOPKINS UNIVERSITY			\$26,810

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AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Tobacco and Systems Change Research Synthesis Conference	HS015758-01	UNIVERSITY OF WISCONSIN MADISON		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Symptom Management: What Works, for Whom & at What Cost?	HS015760-01	JOHNS HOPKINS UNIVERSITY		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Infusing Quality into Practice	HS015960-01	UNIVERSITY OF TEXAS HLTH SCICTR SAN ANT		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Impacts of the Physical Environment on Health Care	HS015962-01	GEORGIA INSTITUTE OF TECHNOLOGY		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Center for Excellence in Health Care Journalism Conferen	HS016071-01	CENTER FOR EXCELLENCE IN HLTH CARE JOURN		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Conference on Complementary and Alternative Medicine	HS016232-01	HENRY FORD HEALTH SYSTEM		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	The National Quality Forum - Annual Meeting 2005	HS016276-01	NATIONAL QUALITY FORUM		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	5th Annual Forum for Improving Children's Health Care	HS016279-01	NATL INITIATIVE/CHILDREN'S HLTHCARE QUAL		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Health Care Practice Priorities/Process/Problem-Solving	HS016281-01	AMERICAN MEDICAL DIRECTORS ASSOC FDN		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Disparities-Social Change: Making Difference the Ground	HS016282-01	HEALTH CARE FOR ALL		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	2005 Public Health Data Standards Consortium Annual Meeting	HS016073-01	PUBLIC HEALTH DATA STANDARDS CONSORTIUM		\$24,999
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Creating a National Telehealth Nursing Research Agenda	HS015961-01	UNIVERSITY OF TEXAS MEDICAL BR GALVESTON		\$24,925
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Global Summit Consensus Conference	HS015756-01	FRED HUTCHINSON CANCER RESEARCH CENTER		\$24,901
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Roadmap to Safe Motherhood	HS015759-01	JACOBS INSTITUTE OF WOMEN'S HEALTH		\$24,848

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AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Prescription Drug Expenditures: Too Much or Not Enough? A Question of Perspective	HS016200-01	UNIVERSITY OF ILLINOIS AT CHICAGO		\$24,776
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Conference: Translational Research for Quality Health	HS015706-01	COLUMBIA UNIVERSITY HEALTH SCIENCES		\$24,775
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Chronic Disease: Complexity Science Perspectives	HS015707-01	PLEXUS INSTITUTE		\$24,658
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Young Caregivers: Who They Are and What They Need	HS015957-01	NATIONAL ALLIANCE FOR CAREGIVING		\$24,505
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Conference--Disaster Medicine & Emergency Management	HS016204-01	YALE NEW HAVEN HEALTH SYSTEM		\$21,882
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Scientific Conference-Assessing Quality Care-Diabetes	HS016280-01	UNIVERSITY OF MICHIGAN AT ANN ARBOR		\$21,802
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Alternative Study Designs for Evidence-Based Practice	HS015954-01	VANDERBILT UNIVERSITY		\$19,202
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Building an Evidence-Based Transition to Practice	HS015958-01	FOUNDATION FOR NURSING EXCELLENCE		\$18,643
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Health Disparities and Hispanic Research	HS016074-01	NATIONAL HISPANIC MEDICAL ASSOCIATION		\$15,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Patient Care & Practice-based Learning & Improvement	HS016199-01	ACCREDITATION COUNCIL-GRAD MED EDUC		\$11,350
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	The Risky Business of Risk Communication	HS016202-01	RHODE ISLAND HOSPITAL (PROVIDENCE, RI)		\$10,234
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	2005 International Conference on Health Policy Research	HS016201-01	AMERICAN STATISTICAL ASSOCIATION		\$10,000
					AHRQ Total =	\$8,312,022

Administration on Aging (AoA)					
AoA	Planning Grants Program	AZ Planning Grant	90AM3028	Arizona Department of Economic Security	\$120,000
AoA	Planning Grants Program	KY Planning Grant	90AM3031	Kentucky Cabinet for Health and Family Services	\$120,000
AoA	Planning Grants Program	PA Planning Grant	90AM3027	Pennsylvania Department of Aging	\$119,820
AoA	Planning Grants Program	FL Planning Grant	90AM3024	Florida Department of Elder Affairs	\$119,250
AoA	Planning Grants Program	IN Planning Grant	90AM3026	Indiana Division of Disability, Aging	\$119,250
AoA	Planning Grants Program	NJ Planning Grant	90AM3030	New Jersey Department of Health and Family Services	\$119,058
AoA	Planning Grants Program	MN Planning Grant	90AM3029	Minnesota Board on Aging	\$106,800
AoA	Planning Grants Program	NC Planning Grant	90AM3025	North Carolina Department of Health and Human Services	\$42,195
AoA Total =					\$866,373

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Centers for Disease Control and Prevention (CDC)						
CDC	A Cooperative Agreement for the Alzheimer's Association to Partner and Implement Public Health Strategies Related to Alzheimer's disease	DP325027		N	Y	\$1,400,382
CDC	A Cooperative Agreement to Advance the Practice of Preventive Medicine	U503000860	Enhance Preparation Of Public Health & Primary Care Physicians	N	Y	\$5,754,386
CDC	A Cooperative Agreement to Improve the Interaction between Public Health Academicians and Public Health Practitioners	U36300430	CA To ASPH For The Improvement Of Interaction Between PHAS And PHPS	N	Y	\$18,153,465
CDC	A Cooperative Agreement to Strengthen Collaboration between the Disciplines of Academic Medicine and Public Health	U36319276	Cooperative Agreement With The Association Of American Medical Colleges	N	Y	\$4,911,793
CDC	Administrative And Technical Support For Hiv Lab Activities In Brazil	U62024829	Administrative And Technical Support For Hiv Lab Activities In Brazil	N	Y	\$325,000
CDC	Antimalaria Drug Resistance and Prevention of Malaria During Pregnancy	U01CI0000320	Effectiveness of two strategies to prevent Malaria during Pregnancy in Mali	N	Y	\$60,000
CDC	Assessment of the Health Effects from Exposure to Volcanic Emission	R01 EH000111	Assessment of the Health Effects from Exposure to Volcanic Emission	N	Y	\$76,847
CDC	Capacity Building Asst. For Global HIV/AIDS Program Development Through Technical Assistance collaboration with the National Association of State and Territorial AIDS Directors	U62/PS324596	Capacity Building Asst. For Global HIV/AIDS Program Development Through Technical Assistance collaboration with the National Association of State and Territorial AIDS Directors	N	Y	\$1,696,191

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CDC	Capacity Building Asst. For Global HIV/AIDS Program Development Through Technical Assistance collaboration with the National Association of State and Territorial AIDS Directors	Capacity Building Asst. For Global HIV/AIDS Program Development Through Technical Assistance collaboration with the National Association of State and Territorial AIDS Directors	U62/PS324596	National Association of State and Territorial AIDS Directors (NASTAD)	N	Y	\$1,696,191
CDC	Centers for Disease Control and Health Promotion Directors of Health Promotion and Education	Centers for Disease Control and Health Promotion Directors of Health Promotion and Education	DP325029	Assn/State/Terr Dir/Hlth Prom/Pub Hlth	N	Y	\$1,670,318
CDC	Comparisons of Community with Facility Management of Malaria and Pneumonia in Rural Tanzania	Comparisons of Community with Facility Management of Malaria and Pneumonia in Rural Tanzania	U01CI000316	Ifakara Health Research	N	Y	\$306,998
CDC	Cooperative Agreement with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Through the World Health Organization (WHO) as Bona Fide Agent	Cooperative Agreement with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Through the World Health Organization (WHO) as Bona Fide Agent	U62/PS025108	World Health Organization/UNAIDS	N	Y	\$3,280,000
CDC	Cooperative Agreement with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Through the World Health Organization (WHO) as Bona Fide Agent	Cooperative Agreement with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Through the World Health Organization (WHO) as Bona Fide Agent	U62/PS025108	World Health Organization/UNAIDS	N	Y	\$3,280,000
CDC	Cooperative Agreement with the Kenya Medical Research Institute (KEMRI)	Cooperative Agreement with the Kenya Medical Research Institute (KEMRI)	U19CI000323	KEMRI	N	Y	\$20,422,739
CDC	Development of Influenza Surveillance Network in Vietnam	Development of Influenza Surveillance Network in Vietnam	U50CI024624	National Institute of Hygiene and Epidemiology	N	Y	\$400,000
CDC	Diabetes Prevention and Control Project in the Americas	U.S. Mexico Border Diabetes Prevention and Control	DP000604	Pan American Health Organization (DC)	N	Y	\$539,000
CDC	Environmental Health Academic Programs	Environmental Health Academic Programs	U50/CCU024903	Association of Environmental Academic Programs	N	Y	\$179,999

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CDC	Ethiopia-Strengthening HIV/AIDS, TB and STI Prevention, Control and Treatment Activities with the Police Force of Ethiopia	Ethiopia-Strengthening HIV/AIDS, TB and STI Prevention, Control and Treatment Activities with the Police Force of Ethiopia	DP000340	Cohn's and Colitis Foundation of America, Inc.	N	Y	\$692,682
CDC	Health Promotion and Non-Communicable Disease and Injury Prevention Initiative in Latin America and the Caribbean	Health Promotion and Non-Communicable Disease and Injury Prevention Initiative in Latin America and the Caribbean	USDP234883	Pan American Health Organization	N	Y	\$253,215
CDC	Information Interchange and Technical Assistance for Human Immunodeficiency Virus (HIV) Prevention	Information Interchange and Technical Assistance for Human Immunodeficiency Virus (HIV) Prevention	5 U62 PS 300609	The US Conference of Mayors Research and Information Found	N	Y	\$730,000
CDC	Information Interchange and Technical Assistance for Human Immunodeficiency Virus (HIV) Prevention -- Community-Based HIV Prevention	U.S. Conference of Mayors	5 U62 PS 300609	The US Conference of Mayors Research and Information Found	N	Y	\$1,469,231
CDC	Interstitial Cystitis Association	Interstitial Cystitis Association	DP325075	Interstitial Cystitis Association	N	Y	\$510,000
CDC	Lance Armstrong Foundation	Lance Armstrong Foundation	DP624967	Lance Armstrong Foundation	N	Y	\$729,996
CDC	Mind/Body Research and Chronic Disease Conditions	Mechanisms & Therapeutic Effects of Relaxation Response	R01 DO000339	Beth Israel Deaconess Medical Center	N	Y	\$1,916,915
CDC	National Training & Mentoring Program To Strengthen Yct Programs In Malawi	National Training & Mentoring Program To Strengthen Yct Programs In Malawi	U6202462	Malawi Aids Counseling & Resource Org	N	Y	\$191,218
CDC	Pilot Projects to Expand Existing Birth Defects Surveillance Systems to Include All Fetal Death Data	Pilot Projects to Expand Existing Birth Defects Surveillance Systems to Include All Fetal Death Data	DD725183	Iowa Dept of Public Health	N	Y	\$761,975
CDC	Pioneering Healthier Communities	Pioneering Healthier Communities	DP325027	YMCA of the US	N	Y	\$5,383,032

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CDC	Preventing Maternal Neonatal bacterial Infections in Developing Settings with High Prevalence of HIV in Soweto, South Africa	Preventing Maternal Neonatal bacterial Infections in Developing Settings with High Prevalence of HIV in Soweto, South Africa	U01CID000318	South African Medical Research Council	N	Y	\$248,119
CDC	Reducing Sexual Risk in Southern HIV-Positive Women	Reducing Sexual Risk in Southern HIV- Positive Women	U01000100	University Of North Carolina Chapel Hill	N	Y	\$197,975
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP124586-01	KHMER HEALTH ADVOCATES			\$387,500
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP324583-01	NATIONAL LATINA HEALTH NETWORK			\$387,500
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP324584-01	NATIONAL ALLIANCE FOR HISPANIC HEALTH			\$387,500
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP324588-01	BLACK WOMEN'S HEALTH IMPERATIVE			\$387,500
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP824590-01	NATIONAL ASSOCIATION OF SCHOOL NURSES INC			\$387,500
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP924591-01	PAPA OLA LOKAHI			\$387,500
CDC		NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP324585-01	NATIONAL MEDICAL ASSOCIATION			\$375,000
CDC		Behavioral Social and Cultural Determinants of HIV Risk in Hispanic Women	1 U01 PS000084-01	UNIVERSITY OF MIAMI SCHOOL OF MEDICINE			\$332,141
CDC		HIV Epidemiology Among African American Women in North Carolina	1 U01 PS000094-01	UNIVERSITY OF NORTH CAROLINA CHAPEL HILL			\$310,506

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CDC	NATIONAL PROGRAM TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMM.	1 U58 DP624589-01	ASSOCIATION OF AMERICAN INDIAN PHYSNS			\$300,000
CDC	Surveillance of HIV/AIDS Related Events Among Persons Not Receiving Care in NJ	1 U01 PS000113-01	NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS			\$300,000
CDC	FETAL ALCOHOL SYNDROME REGIONAL TRAINING CENTERS	1 U84 DD225035-01	UNIV OF MED/DEPT OF NJ-MEDICAL SCHOOL			\$278,900
CDC	FETAL ALCOHOL SYNDROME REGIONAL TRAINING CENTERS	1 U84 DD425037-01	MEHARRY MEDICAL COLLEGE			\$278,900
CDC	FETAL ALCOHOL SYNDROME REGIONAL TRAINING CENTERS	1 U84 DD725041-01	SAINT LOUIS UNIVERSITY			\$278,900
CDC	FETAL ALCOHOL SYNDROME REGIONAL TRAINING CENTERS	1 U84 DD925033-01	UNIVERSITY OF CALIFORNIA LOS ANGELES			\$278,900
CDC	Factors Promoting High Risk and Protective Behaviors Among African-American Women	1 U01 PS000097-01	HEALTH SERVICES CENTER, INC.			\$271,526
CDC	Surveillance of HIV/AIDS Related Events Among Persons Not Receiving Care	1 U01 PS000116-01	INDIANA STATE DEPARTMENT OF HEALTH			\$242,535
CDC	Surveillance of HIV/AIDS Related Events Among Persons Not Receiving Care	1 U01 PS000109-01	WASHINGTON STATE DEPT SOC/HLTH SERVICES			\$241,810
CDC	Surveillance of HIV/AIDS Related Events Among Persons Not Receiving Care	1 U01 PS000108-01	NEW YORK CITY HEALTH/MENTAL HYGIENE			\$235,048
CDC	Surveillance of HIV/AIDS Related Events Among Persons Not Receiving Care	1 U01 PS000114-01	CITY OF PHILADELPHIA PUBLIC HEALTH DEPT			\$215,301
CDC	COLLABORATIVE EFFORTS TO PREVENT CHILD ABUSE (II)	1 H28 CE425050-01	PREVENT CHILD ABUSE GEORGIA			\$208,334
CDC	COLLABORATIVE EFFORTS TO PREVENT CHILD ABUSE (II)	1 H28 CE125051-01	MASSACHUSETTS CITIZENS FOR CHILDREN, INC			\$208,333
CDC	COLLABORATIVE EFFORTS TO PREVENT CHILD ABUSE (II)	1 H28 CE525052-01	PROJECT PATHFINDER, INC.			\$208,333
CDC	Reducing Sexual Risk in Southern HIV-Positive Women	1 U01 PS000100-01	UNIVERSITY OF NORTH CAROLINA CHAPEL HILL			\$197,975

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CDC	DEVELOPMENT AND IMPROVEMENT OF POPULATION-BASED BIRTH DEFECTS SURVEILLANCE	5 U50 DD321127-04	VIRGINIA STATE DEPT OF HEALTH			\$180,000
CDC	ENHANCED STATE-BASED BIRTH DEFECT SURVEILLANCE AND USE OF SURVEILLANCE DATA	2 U50 DD816062-07	COLORADO STATE DEPT/PUB HLTH & ENVIRONMT			\$180,000
CDC	ENHANCED STATE-BASED BIRTH DEFECT SURVEILLANCE AND USE OF SURVEILLANCE DATA	5 U50 DD516051-07	MICHIGAN STATE DEPT OF PUBLIC HEALTH			\$180,000
CDC	DEVELOPMENT AND IMPROVEMENT OF POPULATION-BASED BIRTH DEFECTS SURVEIL OF LI	5 U50 DD121143-04	COLUMBIA COLLEGE			\$150,000
CDC	ENHANCED STATE-BASED BIRTH DEFECT SURVEILLANCE AND USE OF SURVEILLANCE DATA	5 U50 DD616021-07	OKLAHOMA STATE DEPARTMENT OF HEALTH			\$150,000
CDC	PREVENTING SEXUAL AND INTIMATE PARTNER VIOLENCE WITHIN RACIAL/ETHNIC MINORI	1 U54 CE924948-01	NATIONAL INDIAN JUSTICE CENTER			\$150,000
CDC	PREVENTING SEXUAL AND INTIMATE PARTNER VIOLENCE WITHIN RACIAL/ETHNIC MINOR	5 U54 CE624949-01	MIGRANT CLINICIANS NETWORK, INC.			\$150,000
CDC	POP-BASED BIRTH DEFECTS SURV. PGM/UTIL. OF SURV. DATA PH PROGRAMS	1 U50 DD124594-01	RHODE ISLAND STATE DEPT OF HEALTH			\$149,989
CDC	DEVELOPMENT AND IMPROVEMENT OF POPULATION-BASED BIRTH DEFECTS SURVEILLANCE	5 U50 DD521124-04	MINNESOTA STATE DEPT OF HUMAN SERVICES			\$110,000
CDC	ENHANCING HEALTHCARE PROVIDER'S ABILITY TO PREVENT SEXUAL VIOLENCE	1 U54 CE324945-01	AMERICAN COLLEGE HEALTH ASSOCIATION			\$100,000
CDC	NATIONAL HEALTH EDUCATION ENHANCEMENT PROGRAM	1 U58 EH224950-01	AMERICAN LUNG ASSOCIATION			\$100,000

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CDC	NATIONAL HEALTH EDUCATION ENHANCEMENT PROGRAM	5 US8 EH324952-01	ALLERGY/ASTHMA NETWK MOTHERS/ASTHMATICS			\$99,998
CDC	ENHANCING HEALTHCARE PROVIDERS ABILITY TO PREVENT SEXUAL VIOLENCE	1 US4 CE524947-01	AMERICAN ACADEMY OF PEDIATRICS			\$99,994
CDC	ASTHMA & ALLERGY FOUNDATION OF AMERICA	5 US8 EH324951-01	ASTHMA & ALLERGY FOUNDATION OF AMERICA			\$99,992
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 H13 DP624980-01	BAYLOR COLLEGE OF MEDICINE			\$99,569
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 H13 DP625012-01	BAYLOR COLLEGE OF MEDICINE			\$99,389
CDC	ENHANCING HEALTHCARE PROVIDERS ABILITY TO PREVENT SEXUAL VIOLENCE	1 US4 CE224946-01	INTERNATIONAL ASSN OF FORENSIC NURSES			\$94,140
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP424990-01	AMERICAN CANCER SOCIETY, INC			\$82,500
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP624988-01	SISTERS NETWORK INC.			\$75,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP224999-01	HEALTH RESEARCH, INC.- ROSWELL PARK CANCER			\$60,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP024697-01	INTERNATIONAL ASSN OF CANCER REGISTRIES			\$51,300
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 H13 DP324619-01	SOCIETY FOR PUBLIC HEALTH EDUCATION, INC			\$50,000

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CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 HI3 DP325011-01	US BREASTFEEDING COMMITTEE		\$50,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 HI3 DP824984-01	NATIONAL STROKE ASSOCIATION		\$50,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP824614-01	NATIONAL CONFERENCE/STATE LEGISLATURES		\$45,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP324620-01	SOCIETY FOR PUBLIC HEALTH EDUCATION, INC		\$40,500
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP524979-01	GYNECOLOGIC CANCER FOUNDATION		\$35,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 HI3 DP324975-01	NATIONAL CANCER REGISTRAR'S ASSOCIATION		\$35,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 HI3 DP924618-01	HAWAII PUBLIC HEALTH ASSOCIATION		\$35,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP424613-01	FOUNDATION FOR HEALTH AMERICA (FUNSALUD)		\$34,925
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP324989-01	SOCIETY FOR PUBLIC HEALTH EDUCATION		\$30,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP424615-01	TEPHINET		\$30,000

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CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 H13 DP424974-01	H. LEE MOFFITT CANCER CTR & RES INST			\$30,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP424986-01	MOREHOUSE SCHOOL OF MEDICINE			\$27,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP424983-01	THE CONSORTIUM FOR SOUTHEASTERN HYP CONT			\$25,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 H13 DP324995-01	THE GEORGE WASHINGTON UNIVERSITY			\$24,430
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP424987-01	MOREHOUSE SCHOOL OF MEDICINE			\$22,500
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP025020-01	OREGON HEALTH & SCIENCE UNIVERSITY			\$20,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP324616-01	NATL ASSN/PUB HLTH STATS & INFORMTN SYS			\$20,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP325019-01	NATIONAL PERINATAL ASSOCIATION			\$20,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP424981-01	MEMORIAL HEALTH FOUNDATION, INC			\$20,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 H13 DP424992-01	SOUTHWEST GEORGIA AREA HLTH EDUC CENTER			\$20,000

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CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	5 HI3 DP525009-01	WISCONSIN FAMILY PLANNING & REPRODUCTIV		\$15,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP324617-01	NATIONAL COALITION/PROMOTING PHYS ACT		\$10,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP624612-01	COOPER INSTITUTE		\$10,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP924973-01	SDSU FOUNDATION		\$10,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP524978-01	AMERICAN COLLEGE OF SPORTS MEDICINE FND		\$5,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP224996-01	THE RESEARCH FOUNDATION OF SUNY AT BIRM		\$5,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP524976-01	AMERICAN COLLEGE OF SPORTS MEDICINE FOUN		\$5,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP524977-01	AMERICAN COLLEGE OF SPORTS MEDICINE		\$5,000
CDC	NATL CTR FOR CHRONIC DISEASE PREV & HLTH PROMO CONFERENCE SUPPORT PROGRAM	1 HI3 DP525001-01	UNIV OF ILLINOIS AT URBANA- CHAMPAIGN		\$5,000
CDC Total =					\$87,521,335

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Centers for Medicare and Medicaid Services (CMS)					
CMS	A Comparison of Multiple Methods to Incent Physicians to Adopt Electronic Prescribing Devices	1R0CMS300044	MedCo Health Solutions	Y	N
				CMS Total =	
					\$200,000

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Food and Drug Administration (FDA)							
FDA	Food and Drug Administration_Research	National Center for Food Safety and Technology	FD-U-000431	ILLINOIS INSTITUTE OF TECHNOLOGY	N	Y	\$3,000,000
FDA	Food and Drug Administration_Research	Botanical Dietary Supplements: Science-Base for Authentication and Analysis	FD-U-002071	UNIVERSITY OF MISSISSIPPI	N	Y	\$855,881
FDA	Food and Drug Administration_Research	Cooperative Agreement to Support the Joint Institute for Food Safety and Applied Nutrition	FD-U-001418	UNIVERSITY OF MARYLAND	N	Y	\$607,100
FDA	Food and Drug Administration_Research	Botanical Dietary Supplements: Science-Base for Authentication and Analysis	FD-U-002071	UNIVERSITY OF MISSISSIPPI	N	Y	\$493,453
FDA	Food and Drug Administration_Research	Assuring Radiation Protection	FD-U-000005	CONFERENCE OF RADIATION PROGRAM DIRECTORS, INC	N	Y	\$453,000
FDA	Food and Drug Administration_Research	L-glutamine Therapy for Sickle Cell Anemia	FD-R-002028	LA BIOMEDICAL RESEARCH INSTITUTE AT HARBOR UCLA MED CTR	N	Y	\$347,409
FDA	Food and Drug Administration_Research	Shellfish Safety Assistance Project	FD-U-000891	INTERSTATE SHELLFISH SANITATION CONFERENCE	N	Y	\$325,000
FDA	Food and Drug Administration_Research	National Center for Food Safety and Technology	FD-U-000431	ILLINOIS INSTITUTE OF TECHNOLOGY	N	Y	\$132,000
FDA	Food and Drug Administration_Research	Improving the Safety of Fresh Fruits & Vegetables - WERC Design Contest	FD-U-001941	NEW MEXICO STATE UNIVERSITY	N	Y	\$106,000
FDA	Food and Drug Administration_Research	International Programme on Chemical Safety	FD-U-000009	WORLD HEALTH ORGANIZATION	N	Y	\$90,000
FDA	Food and Drug Administration_Research	National Center for Food Safety and Technology	FD-U-000431	ILLINOIS INSTITUTE OF TECHNOLOGY	N	Y	\$43,500
FDA	Food and Drug Administration_Research	Proyecto Informar FDA Hispanic Outreach Initiative	FD-U-002260	NATIONAL ALLIANCE FOR HISPANIC HEALTH (THE)	N	Y	\$30,000
FDA	Food and Drug Administration_Research	Interstate Shellfish Conference	IR13FD003061	INTERSTATE SHELLFISH SANITATION CONFERENCE	N	Y	\$25,000
FDA	Food and Drug Administration_Research	AEDO 2005 Annual Educational Conference	IR13FD003054	ASSOCIATION OF FOOD & DRUG OFFICIALS			\$25,000
FDA	Food and Drug Administration_Research	Interstate Shellfish Conference	IR13FD003061	INTERSTATE SHELLFISH SANITATION CONFERENCE			\$25,000

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FDA	Food and Drug Administration Research	NEHA's 69th Annual Educational Conference	IR13FD003088	NATIONAL ENVIRONMENTAL HEALTH ASSOCIATION			\$25,000
FDA	Food and Drug Administration Research	National Egg Regulatory Officials 13th Annual Conference	IR13FD-003047	NATL EGG REGULATORY OFFICIALS			\$25,000
FDA	Food and Drug Administration Research	2005 Public Health Professional Conference	IR13FD003051	PHS COMMISSIONED OFFICERS FOUNDATION			\$25,000
FDA	Food and Drug Administration Research	State Food Safety and Food Security Task Force Meetings Conference Grant Program	IR13FD003185	ALASKA DEPT OF ENVIRONMENTAL CONSERVATION	N	Y	\$7,000
FDA	Food and Drug Administration Research	Food Safety Task Force Conference Grant	FD-R-002628	AZ DEPT. OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration Research	California Food Safety and Security Agency Team Conference	FD-R-002640	CA DEPT OF HEALTH SERVICES	N	Y	\$7,000
FDA	Food and Drug Administration Research	Food Safety Task Force Conference Grant	FD-R-002633	CO ST DEPT PUBLIC HLTH&ENVIRONMENT	N	Y	\$7,000
FDA	Food and Drug Administration Research	Response to Food Safety Task Force Conference Grant Program	IR13FD003068	DELAWARE HEALTH & SOCIAL SERVICES	N	Y	\$7,000
FDA	Food and Drug Administration Research	District of Columbia Food Safety Task Force	FD-R-002657	DEPARTMENT OF HEALTH	N	Y	\$7,000
FDA	Food and Drug Administration Research	Conference Support for State Food Safety and Food Security Advisory Council	IR13FD003067	FL DEPT OF AGRICULTURE & CONSUMER SVCS	N	Y	\$7,000
FDA	Food and Drug Administration Research	Georgia Food Safety Task Force - First Annual Conference	IR13FD003179	GEORGIA DEPT OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration Research	Hawaii Food Safety Task Force Conference on Model Food Code	IR13FD003187	HI DEPT OF HEALTH	N	Y	\$7,000
FDA	Food and Drug Administration Research	Iowa Food Safety Task Force Conference	FD-R-002637	IA ST DEPARTMENT OF INSPECTION & APPEALS	N	Y	\$7,000
FDA	Food and Drug Administration Research	State Food Safety and Security Task Force Meetings	IR13FD003184	IN ST BOARD OF HEALTH	N	Y	\$7,000
FDA	Food and Drug Administration Research	Kansas Food Safety Task Force	FD-R-002642	KS ST DEPARTMENT OF HEALTH & ENVIRONMENT	N	Y	\$7,000
FDA	Food and Drug Administration Research	Michigan Food Safety Task Force Meetings	IR13FD003066	MI ST DEPARTMENT OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration Research	State Food Safety Task Force Meetings	2R13FD002630	MN DEPT OF AGRIC.	N	Y	\$7,000
FDA	Food and Drug Administration Research	North Carolina Division of Public Health	FD-R-002639	NC ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$7,000

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FDA	Food and Drug Administration_Research	Nebraska Food Safety Task Force Conference	FD-R-002632	NE ST DEPARTMENT OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration_Research	New Hampshire State Food Safety Task Force Meetings	FD-R-002629	NH ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$7,000
FDA	Food and Drug Administration_Research	New Hampshire State Food Safety Task Force Meetings	FD-R-002629	NH ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$7,000
FDA	Food and Drug Administration_Research	State Food Safety and Food Security Task Force Meetings	IR13FD003188	NI ST DEPARTMENT OF HEALTH AND SENIOR SERVICES	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Nevada Food Safety Task Force	FD-R-002638	NV ST DAIRY COMMISSION	N	Y	\$7,000
FDA	Food and Drug Administration_Research	New York Food Safety Task Force Meeting	FD-R-002627	NY ST DEPARTMENT OF AGRICULTURE & MARKETS	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Food Safety Task Force Meetings	IR13FD003180	OKLAHOMA DEPT OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration_Research	PA Act 315 Meetings	IR13FD003191	PA DEPT OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Rhode Island State Food Safety Task Force	FD-R-002636	RI ST DEPARTMENT OF HEALTH	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Safety Council	IR13FD003186	SC DEPT OF AGRICULTURE	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Food Safety Task Force Conference Grant	IR13FD003189	TX Dept of State Health Services	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Virginia Food Safety Task Force Meetings	FD-R-002641	VA DEPT OF AGRICULTURE & CONSUMER SVCS	N	Y	\$7,000
FDA	Food and Drug Administration_Research	West Virginia Food Safety and Food Security Task Force Meetings	IR13FD003183	WV ST DEPARTMENT OF HEALTH AND HUMAN RESOURCES	N	Y	\$7,000
FDA	Food and Drug Administration_Research	Communication and cooperation within State among State and local food safety regulatory agencies	IR18FD003178	TN ST DEPARTMENT OF HEALTH	N	Y	\$6,974
FDA	Food and Drug Administration_Research	Food Safety Task Force Conference Grant	FD-R-002622	MO ST DEPARTMENT OF HEALTH & SENIOR SERVICES	N	Y	\$6,955
FDA	Food and Drug Administration_Research	Trainers of Food Safety & Standardization Task Force Workshop	IR13FD003070	AR DEPT OF HEALTH	N	Y	\$5,000

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FDA	Food and Drug Administration Research	Response to Food Safety Task Force Conference Grant Program	IR13FD003182	MA ST DEPARTMENT OF PUBLIC HEALTH	N	Y	\$5,000
FDA	Food and Drug Administration Research	Congress on Assessing & Mitigating Environmental Impacts of Emerging Contaminants	IR13FD003137	RENEWABLE NATURAL RESOURCES FOUNDATION	N	Y	\$5,000
FDA	Food and Drug Administration Research	State Food Safety and Food Security Task Force Meeting Conference Grant Program	IR13FD003190	Wyoming Dept. of Agriculture	N	Y	\$5,000
FDA	Food Safety and Security Monitoring Project	Arizona Food Safety & Security Monitoring Project	IU18 FD003139	AZ ST DEPARTMENT OF HEALTH SERVICES	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	Florida Food Safety & Security Monitoring of FERN Samples	IU18 FD003146	FL ST DEPARTMENT OF AGRICULTURE & CONSERVATION	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	Use of LC/MS, GC/MS and ICP-MS Analysis for the Screening & Identification of Toxic Substances in Food	IU18 FD003177	UNIVERSITY OF CALIFORNIA	N	Y	\$349,740
FDA	Food Safety and Security Monitoring Project	Minnesota Food Safety & Security Monitoring Project	IU18 FD003150	MN DEPT OF AGRIC.	N	Y	\$334,950
FDA	Food Safety and Security Monitoring Project	Virginia Food Safety & Security Monitoring Project	IU18 FD003148	VA ST DEPT OF GENERAL SERVICES	N	Y	\$310,000
FDA	Ruminant Feed Ban Support Project	Iowa Food Safety in the Heartland	IU18 FD003170	UNIVERSITY OF IOWA	N	Y	\$301,655
FDA	Ruminant Feed Ban Support Project	New Hampshire Food Safety (FERN)	IU18 FD003164	NEW HAMPSHIRE DIVISION OF PUBLIC HEALTH	N	Y	\$264,546
FDA	Ruminant Feed Ban Support Project	Michigan Ruminant Feed Ban Support Project	IU18 FD003217	MI DEPT OF AGRICULTURE	N	Y	\$250,000
FDA	Ruminant Feed Ban Support Project	Nebraska Ruminant Feed Ban Support Project	IU18 FD003214	NE ST DEPARTMENT OF AGRICULTURE	N	Y	\$250,000
FDA	Ruminant Feed Ban Support Project	Office of the Texas State Chemist BSE Prevention Program	IU18 FD003215	TEXAS AGRICULTURAL EXPERIMENTAL STATION	N	Y	\$249,852
FDA	Ruminant Feed Ban Support Project	Minnesota Animal Feed Safety & BSE Prevention Program	IU18 FD003213	MN DEPT OF AGRIC.	N	Y	\$239,999
FDA	Ruminant Feed Ban Support Project	Florida Ruminant Feed Ban Enhancement Project	IU18 FD003225	Florida Dept. of Agriculture and Consumer Services	N	Y	\$239,688
FDA	Ruminant Feed Ban Support Project	Illinois Ruminant Feed Ban Support Project	IU18 FD003222	IL DEPT OF AGRICULTURE	N	Y	\$233,528
FDA	Ruminant Feed Ban Support Project	FERN Food Safety Activities at CAES	IU18 FD003157	THE CONNECTICUT AGRICULTURAL EXPERIMENT STATION	N	Y	\$232,324

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Health Resources and Services Administration (HRSA)						
HRSA	Border Health Best Practices	Border Health Best Practices	1 U54RH06345-01-00 US-Mexico Border Health Association		Yes	\$383,000
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10179	NEW YORK UNIVERSITY		\$104,752
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10204	TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA		\$71,947
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10177	NORTHWESTERN UNIVERSITY		\$63,666
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10188	BD. OF REGENTS @ U OF COLORADO AT DENVER		\$61,595
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10185	VIRGINIA COMMONWEALTH UNIVERSITY		\$55,229
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10208	UNIVERSITY OF HOUSTON- CLEAR LAKE		\$53,521
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10186	UNIVERSITY OF ALABAMA AT BIRMINGHAM		\$47,102
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10216	UNIVERSITY OF SOUTHERN CALIFORNIA		\$40,425
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10195	TRINITY UNIVERSITY		\$36,222
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10187	MEDICAL UNIVERSITY OF SOUTH CAROLINA		\$36,228
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10199	TEXAS TECH UNIVERSITY		\$34,162
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10214	WIDENER UNIVERSITY		\$33,593

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HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10190	TEXAS WOMAN'S UNIVERSITY		\$32,144
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10194	XAVIER UNIVERSITY		\$31,296
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP06612	University of Kansas Medical Center Research Institute		\$28,986
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10182	CURATORS OF UNIV. OF MISSOURI - COLUMBIA		\$26,320
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10207	TEMPLE UNIVERSITY SCHOOL OF MEDICINE		\$22,775
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10209	WASHINGTON UNIVERSITY		\$20,187
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10200	SOUTHWEST TEXAS STATE UNIVERSITY		\$17,127
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10192	UNIVERSITY OF FLORIDA		\$16,512
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10201	SIMMONS COLLEGE		\$15,528
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10202	UNIVERSITY OF ARKANSAS AT LITTLE ROCK		\$15,276
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10197	UNION COLLEGE		\$14,493
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10215	WASHINGTON STATE UNIVERSITY		\$14,286
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10219	PENNSYLVANIA STATE UNIVERSITY		\$11,905
HRSA	Health Administration Traineeships and Special Projects	HATSP	A19HP10198	UNIVERSITY OF SCRANTON		\$10,870

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Indian Health Services (IHS)							
IHS	INDIANS INTO MEDICINE	INDIANS INTO MEDICINE	D919400180	UNIV OF ARIZONA	N	Y-LC	\$307,263
IHS	INDIANS INTO PSYCOLOGY	INDIANS INTO PSYCHOLOGY	D94IHS00176	OK STATE UNIV	N	Y-LC	\$244,500
IHS	INDIANS INTO PSYCOLOGY	INDIANS INTO PSYCHOLOGY	D919400144	UNIV OF MONTANA	N	Y-LC	\$244,500
IHS	INDIANS INTO PSYCOLOGY	INDIANS INTO PSYCHOLOGY	D919400018	UNIV OF N DAKOTA	N	Y-LC	\$244,500
IHS	NATIONAL COUNCIL OF URBAN INDIAN HEALTH	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400012	NATIONAL COUNCIL OF URBAN HEALTH	N	Y-SS	\$417,000
IHS	NATIONAL INDIAN HEALTH BOARD	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400013	NATIONAL INDIAN HEALTH COARD	N	Y-SS	\$719,425
IHS	NATIONAL NATIVE AMERICAN EMS ASSOCIATION	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400011	NATIONAL NATIVE AMERICAN EMS ASS	N	Y-SS	\$90,000
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400507	NAVAJO AREA IHS	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400480	RIVERSIDE-SAN BERNADINO	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400537	TOHONO O'ODHAM NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400518	IHS WHITERIVER SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400536	YAKAMA INDIAN HEALTH	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400445	ALBUQUERQUE SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400492	CHOCTAW NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400517	IHS UNITAH & OURAY SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400458	LEECH LAKE BAND	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400467	BLACKFEET	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400500	MUSCOGEE CREEK NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400491	CHICKASAW NATION	N	Y-LC	\$397,100

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IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400512	COLORADO RIVER	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400495	HASKELL HEALTH CTR	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400486	MISSISSIPPI BAND OF CHOCTAW	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400484	UNITED INDIAN HEALTH SERVICE	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400444	SOUTHEAST REGIONAL HEALTH CONSORTIUM	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400442	SOUTHCENTRAL FOUNDATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400534	WARM SPRINGS HEALTH	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400449	PUEBLO OF ZUNI	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400498	LAWTON INDIAN PHS	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400527	COW CREEK BAND	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400541	PINE RIDGE IHS HOSPITAL	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400494	CHEROKEE NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400510	TUBA CITY REGIONAL	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400531	NW WASHINGTON IHB	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400450	RAMAH NAVAJO SCHOOL	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400446	SANTO DOMINGO	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400466	SAULT STE MARIE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400482	TOTYABE INDIAN HEALTH	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400540	YUKON-KUSKOKWIM	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400438	WAGNER HEALTH CARE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400451	TAOS-PICURIS	N	Y-LC	\$324,300

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IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400489	ABSENTEE-SHAWNEE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400453	BAD RIVER BANDS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400468	CONFEDERATED SALISH & KOOTENAI	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400516	HUALAPAI TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400496	INDIAN HEALTH CARE RESOURCE CENTER OF TULSA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400543	MILL LACS BAND	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400533	SEATTLE INDIAN HEALTH BOARD	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400470	FORT BLKNAP INDIAN COMMUNITY	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400478	INDIAN HEALTH COUNCIL	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400479	REDDING RACHERIA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400487	ST REGIS MOHAWK TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400523	BENEWAH MEDICAL CTR	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400431	CHEYENNE RIVER SIOUX	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400525	CONFEDERATED TRIBE OF CHEHALIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400524	COLVILLE CONFEDERATED TRIBES	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400542	FOND DU LAC RESERVATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400477	INDIAN HEALTH CENTER OF SANTA CLARA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400459	MENOMINEE INDIAN TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400539	NORTON SOUND HEALTH CORP	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400473	ROCKY BOY HEALTH BOARD	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400448	PUEBLO OF SAN FELIPE	N	Y-LC	\$324,300

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IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400532	QUINIAULT INDIAN NATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400439	WINNEBAGO TRIBE OF NE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400483	UNITED AMERICAN INVOLVEMENT INDIAN	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400435	TRENTON INDIAN SERVICE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400481	SONOMA COUNTY	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400547	SENECA NATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400538	KENAITZE INDIAN TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400436	RAPID CITY INDIAN HEALTH	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400455	INDIAN HEALTH BOARD OF MINNEAPOLIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400454	HO CHUNK	N	Y-LC	\$324,300
						IHS Total =	\$24,842,388

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National Institutes of Health (NIH)						
NIH	CONFERENCE GRANTS	NATIONAL IDEA SYMPOSIUM OF BIOMEDICAL RESEARCH EXCELLENCE (NISBRE)	U13RR022675-01	IRVIN CHARLES G - UNIVERSITY OF VERMONT & ST AGRIC COLLEGE		\$252,384
NIH	CONFERENCE GRANTS	SYMPOSIUM ON CAREER OPPORTUNITIES IN BIOMEDICAL SCIENCES	R13GM073536-01	CHAMPION PHYLLIS R - ASSN/MINORITY HEALTH PROFESSIONS SCHOOLS		\$185,500
NIH	CONFERENCE GRANTS	CONFERENCE FELLOWSHIPS FOR MINORITY PHYSIOLOGISTS	R13DK039306-19	FRANK MARTIN - AMERICAN PHYSIOLOGICAL SOCIETY		\$129,808
NIH	CONFERENCE GRANTS	CONFERENCE-COLLEGE ON PROBLEMS OF DRUG DEPENDENCE	R13DA019790-01	ADLER MARTIN W - COLLEGE ON PROBLEMS OF DRUG DEPENDENCE		\$116,000
NIH	CONFERENCE GRANTS	ALCOHOL AND INJURY: NEW KNOWLEDGE FROM ER STUDIES	R13AA015484-01	CHEPTEL CHERYL J - PUBLIC HEALTH INSTITUTE		\$101,006
NIH	CONFERENCE GRANTS	INSTITUTE OF HUMAN VIROLOGY ANNUAL MEETING 2005-2010	R13AI046078-06	GALLO ROBERT C - UNIVERSITY OF MD BIOTECHNOLOGY INSTITUTE		\$80,500
NIH	CONFERENCE GRANTS	23RD ANNUAL SYMPOSIUM ON NONHUMAN PRIMATE MODEL FOR AIDS	R13RR021809-01	AXTHELM MICHAEL K - OREGON HEALTH & SCIENCE UNIVERSITY		\$71,286
NIH	CONFERENCE GRANTS	BIOIRON RESEARCH CONFERENCE 2005	R13DK071474-01	KAPLAN JERRY - UNIVERSITY OF UTAH		\$70,000
NIH	CONFERENCE GRANTS	36TH ANNUAL INTERNATIONAL NARCOTICS RESEARCH CONFERENCE	R13DA020341-01	BIDLACK JEAN M - INTERNTL NARCOTICS RESEARCH CONF. INC.		\$65,000
NIH	CONFERENCE GRANTS	CSHL CELLULAR BIOLOGY OF ADDICTION	R13DA019791-01	GRODZICKER TERRI L - COLD SPRING HARBOR LABORATORY		\$56,250
NIH	CONFERENCE GRANTS	2005 GORDON CONFERENCE ON CATECHOLAMINES	R13DA019792-01	SULZER DAVID - GORDON RESEARCH CONFERENCES		\$55,000
NIH	CONFERENCE GRANTS	ADHERENCE INTERVENTIONS FOR DRUG USERS	R13DA019794-01	WILLIAMS ANN B - YALE UNIVERSITY		\$54,834
NIH	CONFERENCE GRANTS	MEETING: GENETIC ANALYSIS: MODEL ORGANISMS TO HUMAN BIOLOGY	R13GM076942-01	JOHNSTON H. MARK - GENETICS SOCIETY OF AMERICA		\$47,000

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NIH	CONFERENCE GRANTS	2005 NNFF CONSORTIUM FOR NF1, NF2 AND SCHWANNOMATOSIS	R13NS053099-01	EPSTEIN JONATHAN A - FOUNDATION CHILDREN'S TUMOR		\$46,000
NIH	CONFERENCE GRANTS	PRIMARY IMMUNE DEFICIENCY CONSORTIUM CONFERENCE	R13AI065141-01	CUNNINGHAM-RUNDLES CHARLOTTE - CLINICAL IMMUNOLOGY SOCIETY		\$42,500
NIH	CONFERENCE GRANTS	NEW PERSPECTIVES IN TRANSPORTER BIOLOGY (FASEB CONFERENCE)	R13NS053280-01	ROBINSON MICHAEL B - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$40,352
NIH	CONFERENCE GRANTS	OVERCOMING COLORECTAL CANCER DISPARITIES	R13CA117386-01	MOSES HAROLD L - VANDERBILT UNIVERSITY		\$40,000
NIH	CONFERENCE GRANTS	E. COLI ANNOTATION WORKSHOP	R13GM074562-01	RILEY MONICA - MARINE BIOLOGICAL LABORATORY		\$40,000
NIH	CONFERENCE GRANTS	CNS MANIFESTATIONS OF TUBEROUS SCLEROSIS COMPLEX	R13NS052034-01	WHITTEMORE VICKY HOLETS TUBEROUS SCLEROSIS ALLIANCE		\$40,000
NIH	CONFERENCE GRANTS	2005 CAG TRIPLET REPEAT DISORDERS GORDON CONFERENCE	R13NS051860-01	LEVINE MICHAEL S - GORDON RESEARCH CONFERENCES		\$39,000
NIH	CONFERENCE GRANTS	TOBACCO CONTROL STRATEGIES FOR MEDICALLY AT-RISK YOUTH	R13CA117417-01	TYC VIDA L - ST. JUDE CHILDREN'S RESEARCH HOSPITAL		\$36,740
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON EPISODIC ATAXIA SYNDROMES	R13NS054550-01	JEN JOANNA C - UNIVERSITY OF CALIFORNIA LOS ANGELES		\$35,161
NIH	CONFERENCE GRANTS	SYMPOSIUM OF CASE STUDIES IN BAYESIAN STATISTICS	R13CA117515-01	KASS ROBERT E - CARNEGIE-MELLON UNIVERSITY		\$35,000
NIH	CONFERENCE GRANTS	CONFERENCE ON HIV VACCINES	R13AI063798-01	WEINHOLD KENT J - KEYSTONE SYMPOSIA		\$35,000
NIH	CONFERENCE GRANTS	ADVANCES IN MIDBRAIN/HINDBRAIN MALFORMATIONS	R13NS053097-01	GLEESON JOSEPH G - UNIVERSITY OF CALIFORNIA SAN DIEGO		\$35,000
NIH	CONFERENCE GRANTS	NATIONAL CONFERENCE UNDERGRADUATE RESEARCH (NCUR)2005	R13GM074579-01	TURNER JAMES E - VIRGINIA MILITARY INSTITUTE		\$34,638
NIH	CONFERENCE GRANTS	THIRD INTL SYMPOSIUM ON COMPUTATIONAL CELL BIOLOGY	R13RR021281-01	COWAN ANN E - UNIVERSITY OF CONNECTICUT SCH OF MED/DNT		\$30,000

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NIH	CONFERENCE GRANTS	ANNUAL CONFERENCE ON TULAREMIA	R13A068344-01	METZGER DENNIS W - ALBANY MEDICAL COLLEGE			\$30,000
NIH	CONFERENCE GRANTS	CONFERENCE--DRUG DEVELOPMENT FOR VIRAL HEPATITIS	R13A066875-01	RICE CHARLES M - INFORMED HORIZONS, LLC			\$30,000
NIH	CONFERENCE GRANTS	MEETING-HORMONAL CONTRACEPTION AND HIV TRANSMISSION	R13A063839-01	CLARK WESLEY H - GYNUITY HEALTH PROJECTS			\$30,000
NIH	CONFERENCE GRANTS	2005 CONFERENCE ON IMPLANTABLE AUDITORY PROSTHESES	R13DC007831-01	SHANNON ROBERT V - HOUSE EAR INSTITUTE			\$30,000
NIH	CONFERENCE GRANTS	LESSONS FOR SUCCESS: DEVELOPING EMERGING SCIENTISTS IN CSD	U13DC007835-01	MOSS SHARON E - AMERICAN SPEECH-LANGUAGE-HEARING ASSN			\$30,000
NIH	CONFERENCE GRANTS	TENTH INTERNATIONAL CONGRESS ON CERIOD LIPOFUSCINOSES	R13NS052016-01	DAWSON GLYN - UNIVERSITY OF CHICAGO			\$30,000
NIH	CONFERENCE GRANTS	DEAFNESS RESEARCH FOUNDATION CLINICAL RESEARCH WORKSHOP	R13DC007837-01	GATES GEORGE A - DEAFNESS RESEARCH FOUNDATION			\$29,962
NIH	CONFERENCE GRANTS	RENAL DISEASE IN MINORITY POPULATIONS AND DEVELOPING NATIONS CONFERENCE GRANT	R13DK072880-01	NORRIS KEITH C - CHARLES R DREW UNIVERSITY OF MED & SCI			\$29,959
NIH	CONFERENCE GRANTS	VETERINARY SCHOLAR SYMPOSIUM 2005	R13RR021791-01	DICKERSON HARRY W - UNIVERSITY OF GEORGIA (UGA)			\$28,896
NIH	CONFERENCE GRANTS	BI-ANNUAL MEETING OF THE ILIUS EXPERT COMMITTEE ON PID	R13A066891-01	GEHA RAIF - CHILDREN'S HOSPITAL BOSTON			\$28,000
NIH	CONFERENCE GRANTS	13TH INTERNATIONAL CAMPYLOBACTER/HELICOBACTER WORKSHOP	R13DK070461-01A1	NACHAMKIN IRVING - UNIVERSITY OF PENNSYLVANIA			\$27,993
NIH	CONFERENCE GRANTS	ICUH - 4TH ANNUAL CONFERENCE	R13DA020999-01	VLAHOV DAVID H - NEW YORK ACADEMY OF MEDICINE			\$27,589
NIH	CONFERENCE GRANTS	CONFERENCE: THE SCIENCE OF ADDICTION: POLICY IMPLICATION	R13DA020337-01	TANCREDI LAURENCE R - ICAMI			\$25,541

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NIH	CONFERENCE GRANTS	ANNUAL BLOOD-BRAIN BARRIER CONSORTIUM MEETING	R13CA086959-06	NEUWELT EDWARD A - OREGON HEALTH & SCIENCE UNIVERSITY			\$25,000
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON 'AUTOIMMUNITY'	R13AI065123-01	MILLER STEPHEN D - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$25,000
NIH	CONFERENCE GRANTS	ARNMD 84TH ANNUAL CONFERENCE	R13DA019352-01	BARCHAS JACK - ASSOCIATION FOR RESEARCH/NERV & MENT DIS			\$25,000
NIH	CONFERENCE GRANTS	DRUG ABUSE PREVENTION RESEARCH METHODOLOGY CONFERENCES	R13DA020334-01	LANZA STEPHANIE T - PENNSYLVANIA STATE UNIVERSITY-UNIV PARK			\$25,000
NIH	CONFERENCE GRANTS	REGULATION AND DEVELOPMENT OF THE PREFRONTAL CORTEX	R13DA020331-01	HABER SUZANNE N - UNIVERSITY OF ROCHESTER			\$25,000
NIH	CONFERENCE GRANTS	SCIENTIFIC MEETING OF ISRI	R13DA020339-01	MOELLER FREDERICK GERARD - UNIVERSITY OF TEXAS HLTH SCI CTR HOUSTON			\$25,000
NIH	CONFERENCE GRANTS	THE 2005 ADDICTION HEALTH SERVICES RESEARCH CONFERENCE	R13DA020356-01	GRELLA CHRISTINE - UNIVERSITY OF CALIFORNIA LOS ANGELES			\$25,000
NIH	CONFERENCE GRANTS	USA-CARDIBBEAN CONF.: DRUG ABUSE & HIV/AIDS PROGRESSION	R13DA019354-01	DIAZ PEREZ CLEMENTE - UNIVERSITY OF PUERTO RICO MED SCIENCES			\$25,000
NIH	CONFERENCE GRANTS	6TH INTERNATIONAL SYMPOSIUM ON FAP DISORDERS AND 5TH... INNOVATIONS CONFERENCE	R13DK071452-01	BUXBAUM JOEL N - SCRIPPS RESEARCH INSTITUTE			\$25,000
NIH	CONFERENCE GRANTS	CHILDHOOD OBESITY: UPDATE AND INNOVATIONS CONFERENCE	R13DK074312-01	BLAIR STEVEN N - COOPER INSTITUTE			\$25,000
NIH	CONFERENCE GRANTS	4TH INTERNATIONAL CONFERENCE ON BIOCHEMICAL MARKERS FOR BRAIN DAMAGE	R13NS053286-01	BOKESCH PAULA M - EMORY UNIVERSITY			\$25,000
NIH	CONFERENCE GRANTS	ROUTE 28 SUMMITS IN NEUROBIOLOGY	R13NS053098-01	PALMER THEO D - STANFORD UNIVERSITY			\$25,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM ON NEURAL REGENERATION	R13NS054305-01	MADISON ROGER D - DUKE UNIVERSITY			\$25,000

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NIH	CONFERENCE GRANTS	"VIVAX MALARIA RESEARCH: 2005 AND BEYOND"	R13AI068347-01	CARLTON JANE - INSTITUTE FOR GENOMIC RESEARCH			\$24,707
NIH	CONFERENCE GRANTS	13TH ANNUAL INTERNATIONAL CONFERENCE ON MICROBIAL GENOMES	R13AI067245-01	BLATTNER FREDERICK R - UNIVERSITY OF WISCONSIN MADISON			\$24,000
NIH	CONFERENCE GRANTS	4TH INTERNATIONAL EOSINOPHIL SYMPOSIUM	R13AI065122-01	ACKERMAN STEVEN J - UNIVERSITY OF ILLINOIS AT CHICAGO			\$24,000
NIH	CONFERENCE GRANTS	PATHOGEN-HOST STANDOFF: PERSISTENT AND LATENT INFECTION	R13AI066893-01	MOCARSKI EDWARD S - KEYSTONE SYMPOSIA			\$24,000
NIH	CONFERENCE GRANTS	THE MOUSE AS AN INSTRUMENT FOR EAR RESEARCH II	R13DC007832-01	JOHNSON KENNETH R - JACKSON LABORATORY			\$23,125
NIH	CONFERENCE GRANTS	MATH MODELS: EXPERIMENTAL NUTRITION/HEALTH SCIENCES	R13DK074302-01	HANIGAN MARK D - VIRGINIA POLYTECHNIC INST AND ST UNIV			\$23,000
NIH	CONFERENCE GRANTS	NUTRIENT CONTROL OF GENE EXPRESSION & CELL SIGNALING	R13DK071458-01	TOWLE HOWARD C - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$23,000
NIH	CONFERENCE GRANTS	RED CELL GORDON CONFERENCE	R13DK071464-01	ZON LEONARD I - GORDON RESEARCH CONFERENCES			\$23,000
NIH	CONFERENCE GRANTS	9TH INTERNATL MEETING ON NEURAL TRANSPLANTATION & REPAIR	R13NS052100-01	SLADEK JOHN RICHARD - UNIVERSITY OF COLORADO DENVER/HSC AURORA			\$23,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE- IMMUNORECEPTORS	R13AI066860-01	CAMBER JOHN C - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$22,500
NIH	CONFERENCE GRANTS	VIRUSES AND CELLS GORDON CONFERENCE	R13AI065104-01	RICE CHARLES M - GORDON RESEARCH CONFERENCES			\$22,500
NIH	CONFERENCE GRANTS	23RD - 27TH ANNUAL NATIONAL NEUROTRAUMA SYMPOSIUM	R13NS040815-06	DIETRICH W. DALTON - UNIVERSITY OF MIAMI SCHOOL OF MEDICINE			\$22,000
NIH	CONFERENCE GRANTS	SOCIETY FOR THE STIMULUS PROPERTIES OF DRUGS SATELLITE	R13DAI020367-01	WALKER ELLEN ANN - TEMPLE UNIVERSITY			\$21,795

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NIH	CONFERENCE GRANTS	AQUATIC MODELS OF HUMAN DISEASE	R13R022174-01	WINN RICHARD N - UNIVERSITY OF GEORGIA (UGA)			\$20,500
NIH	CONFERENCE GRANTS	MOLECULAR PATHOLOGY OF LUNG CANCER	R13CA115237-01	MINNA JOHN D - AMERICAN ASSOCIATION FOR CANCER RESEARCH			\$20,000
NIH	CONFERENCE GRANTS	2005 (OCULOMOTOR SYSTEM BIOLOGY) GORDON CONFERENCE	R13EY016649-01	GANDHI NEERAJ J - GORDON RESEARCH CONFERENCES			\$20,000
NIH	CONFERENCE GRANTS	6TH INTERNATIONAL CONF. ON CRYPTOCOCCUS & IMMUNE EVASION	R13AI063840-01	LEVITZ STUART M - BOSTON MEDICAL CENTER			\$20,000
NIH	CONFERENCE GRANTS	ASM CONFERENCE ON VIRAL IMMUNE EVASION	R13AI065190-01	VIRGIN HERBERT W - AMERICAN SOCIETY FOR MICROBIOLOGY			\$20,000
NIH	CONFERENCE GRANTS	CONFERENCE ON HIV PATHOGENESIS	R13AI064224-01	LEDERMAN MICHAEL M - KEYSTONE SYMPOSIA			\$20,000
NIH	CONFERENCE GRANTS	INTL CONG OF VIROLOGY, SAN FRANCISCO, ASV TRAVEL REQUEST	R13AI062166-01	SPEAR PATRICIA G - AMERICAN SOCIETY FOR VIROLOGY, INC.			\$20,000
NIH	CONFERENCE GRANTS	CYBERTHERAPY CONFERENCE 2005-2009	R13DA019793-01	WIEDERHOLD BRENDA K - INTERACTIVE MEDIA INSTITUTE			\$20,000
NIH	CONFERENCE GRANTS	ADIPOGENESIS, OBESITY AND INFLAMMATION	R13DK072700-01	SCHERER PHILIPP E - KEYSTONE SYMPOSIA			\$20,000
NIH	CONFERENCE GRANTS	AGENT-BASED MODELING OF ENVIRONMENTAL CORRELATES OF OBESITY EPIDEMIC IN IL	R13DK072698-01	ZHU WEIMO - UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN			\$20,000
NIH	CONFERENCE GRANTS	NIH STUDENT CONFERENCE	R13GM060664-06	GUTIERREZ-HARTMANN ARTHUR - UNIVERSITY OF COLORADO DENVER HSC AURORA			\$20,000
NIH	CONFERENCE GRANTS	CONFERENCE ON AXONAL CONNECTIONS	R13NS050911-01	STRITTMATTER STEPHEN M - KEYSTONE SYMPOSIA			\$20,000
NIH	CONFERENCE GRANTS	LYSOSOMAL DISEASE NETWORK-2ND ANNUAL WORLD SYMPOSIUM	R13NS053341-01	WHITLEY CHESTER B - UNIVERSITY OF MINNESOTA TWIN CITIES			\$20,000
NIH	CONFERENCE GRANTS	BASAL GANGLIA, DOPAMINE, AND LEARNING CONFERENCE	R13NS050865-01	GLUCK MARK A - RUTGERS THE STATE UNIV OF NJ NEWARK			\$20,000

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NIH	CONFERENCE GRANTS	WORKSHOP ON BIOMEDICAL COMPUTATIONS ON THE GRID	R13LM008619-01	HUANG CHUN-HSI - UNIVERSITY OF CONNECTICUT STORRS			\$20,000
NIH	CONFERENCE GRANTS	PASTEURCELLACEAE 2005	R13AI066868-01	MUNSON ROBERT S. - AMERICAN SOCIETY FOR MICROBIOLOGY			\$19,800
NIH	CONFERENCE GRANTS	CANCER DECISION TOOL SYMPOSIUM AT SMDM ANNUAL MEETING	R13CA117811-01	BARNATO AMBER E. - UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$19,664
NIH	CONFERENCE GRANTS	2005 ANTIMICROBIAL PEPTIDES GORDON CONFERENCE	R13AI065005-01	OUELLETTE ANDRE J. - GORDON RESEARCH CONFERENCES			\$19,000
NIH	CONFERENCE GRANTS	GUT HORMONES/OTHER CIRCULATORY REGULATORS OF APPETITE	R13DK074282-01	BLOOM STEPHEN R. - KEYSTONE SYMPOSIA			\$19,000
NIH	CONFERENCE GRANTS	XVIII INTERNATIONAL CONGRESS OF NUTRITION SUPPORT	R13DK071456-01	ALLISON RICHARD G. - AMERICAN SOCIETY FOR NUTRITIONAL SCIENCES			\$18,000
NIH	CONFERENCE GRANTS	SPRING BRAIN CONFERENCE	R13NS048177-02	WOOLSEY THOMAS A. - WASHINGTON UNIVERSITY			\$18,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON HEPATITIS B VIRUSES	R13AI066894-01	BLOCK TIMOTHY M. - DREXEL UNIVERSITY			\$17,500
NIH	CONFERENCE GRANTS	SIXTH INTERNATIONAL CONFERENCE ON SYSTEMS BIOLOGY (ICSB 2005)	R13GM076943-01	MURRAY ANDREW W. - HARVARD UNIVERSITY			\$17,325
NIH	CONFERENCE GRANTS	CONFERENCE OF THE SOCIETY FOR NATURAL IMMUNITY	R13AI068402-01	YOKOYAMA WAYNE M. - WASHINGTON UNIVERSITY			\$16,800
NIH	CONFERENCE GRANTS	HIV DART-FRONTIERS IN DRUG DEVELOPMENT FOR ARV THERAPIES	R13AI065203-01	SCHINAZI RAYMOND F. - INFORMED HORIZONS, LLC			\$16,500
NIH	CONFERENCE GRANTS	7TH INTERNATIONAL WORKSHOP ON PRIMARY HYPEROXALURIA	R13DK070450-01	MILLINER DAWN S. - MAYO CLINIC COLL OF MEDICINE, ROCHESTER			\$16,500
NIH	CONFERENCE GRANTS	11TH ANNUAL STFRBM MEETING	R13CA113029-01	FREI BALZ B. - OREGON STATE UNIVERSITY			\$16,000
NIH	CONFERENCE GRANTS	INTERNATIONAL MEETING-- EPITHELIAL/MESENCHYMAL TRANSITION	R13CA117785-01	KALLURI RAGHU - BETH ISRAEL DEACONESS MEDICAL CENTER			\$16,000

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NIH	CONFERENCE GRANTS	THE 4TH INTRADUCTAL APPROACH TO BREAST CANCER SYMPOSIUM	R13CA115177-01	LOVE SUSAN M. - DR. SUSAN LOVE RESEARCH FOUNDATION			\$16,000
NIH	CONFERENCE GRANTS	2005 TUBERCULOSIS DRUG DEVELOPMENT GORDON CONFERENCE	R13AI066896-01	SACCHETTINI JAMES C - GORDON RESEARCH CONFERENCES			\$16,000
NIH	CONFERENCE GRANTS	CRITICAL RESEARCH ISSUES IN ESSENTIAL TREMOR	R13NS052017-01	ELBLE RODGER - SOUTHERN ILLINOIS UNIVERSITY CARBONDALE			\$16,000
NIH	CONFERENCE GRANTS	NEURAL CIRCUITS AND PLASTICITY GORDON CONFERENCE	R13NS052031-01	TURRIGIANO GINA G - GORDON RESEARCH CONFERENCES			\$16,000
NIH	CONFERENCE GRANTS	BUILDING BRIDGES TO ENHANCE QUALITY OF LIFE	R13CA119855-01	HAYS RONALD - INTERN'L SOCIETY FOR QLTY OF LIFE RES			\$15,000
NIH	CONFERENCE GRANTS	LATINO CANCER DISPARITIES CONFERENCE: CLOSING THE GAP	R13CA119898-01	PATIERNO STEVEN R - GEORGE WASHINGTON UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	MATRIX METALLOPROTEINASES GORDON CONFERENCE	R13CA115182-01	WERB ZENA - GORDON RESEARCH CONFERENCES			\$15,000
NIH	CONFERENCE GRANTS	CONFERENCE PROPOSAL: THE BIOLOGY AND CHEMISTRY OF VISION	R13EY016675-01	CORNWALL M CARTER - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$15,000
NIH	CONFERENCE GRANTS	2005 STAPHYLOCOCCAL DISEASES GORDON RESEARCH CONFERENCES	R13AI066878-01	LEE JEAN C. - GORDON RESEARCH CONFERENCES			\$15,000
NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR RICKETTSIOLOGY CONFERENCE	R13AI066872-01	GANTA ROMAN R. - KANSAS STATE UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	SIGNAL TRANSDUCTION IN THE IMMUNE SYSTEM-FASEB CONF.	R13AI065155-01	KORETZKY GARY A. - FEDERATION OF AMERICAN SOCIETIES FOR EXP			\$15,000
NIH	CONFERENCE GRANTS	INNOVATIONS IN GASTROINTESTINAL RESEARCH AND THERAPY: FASEB SUMMER CONFERENCE	R13DK072697-01	MONTROSE MARSHALL H - UNIVERSITY OF CINCINNATI			\$15,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONGRESS OF MUCOSAL IMMUNOLOGY	R13DK072531-01	MAYER LLOYD F - MOUNT SINAI SCHOOL OF MEDICINE OF NYU			\$15,000

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NIH	CONFERENCE GRANTS	ADVANCING THE STUDY OF STROKE IN WOMEN	R13NS052015-01	BUSHNELL CHERYL D - DUKE UNIVERSITY		\$15,000
NIH	CONFERENCE GRANTS	CONG INTL. SOC VASCULAR BEHAVIORAL & COGNITIVE DISORDERS	R13NS052985-01	FRIEDLAND ROBERT PAUL - CASE WESTERN RESERVE UNIVERSITY		\$15,000
NIH	CONFERENCE GRANTS	NEURAL TUBE DEFECTS CONFERENCE 2005 AND BEYOND	R13NS053284-01	SPEER MARCY C. - DUKE UNIVERSITY		\$15,000
NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR NEUROCHEMISTRY: ANNUAL CONFERENCE GRANT	R13NS054456-01	DEVRIES GEORGE H - AMERICAN SOCIETY FOR NEUROCHEMISTRY		\$15,000
NIH	CONFERENCE GRANTS	FETAL ALCOHOL SYNDROME STUDY GROUP ANNUAL MEETING	R13AA015661-01	SULK KATHLEEN K - UNIVERSITY OF NORTH CAROLINA CHAPEL HILL		\$14,750
NIH	CONFERENCE GRANTS	LYMPHOCYTES/IMMUNE SYSTEM/CELLULAR/INTERACTIVE MECHANISM	R13AI066870-01	KENTER AMY L - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$14,000
NIH	CONFERENCE GRANTS	STRATEGIES TO REDUCE HLTH INEQUITIES FOR AMERICA INDIANS	R13DK071454-01	LIPMAN TERRI H - UNIVERSITY OF PENNSYLVANIA		\$13,800
NIH	CONFERENCE GRANTS	CONFERENCE ON DRUGS AGAINST PROTOZOAN PARASITES	R13AI063800-01	PHILLIPS MARGARET A - KEYSTONE SYMPOSIA		\$13,750
NIH	CONFERENCE GRANTS	CONFERENCE--MOLECULAR HELMINTHOLOGY, INTEGRATED APPROACH	R13AI063801-01	LOVERDE PHILIP T - KEYSTONE SYMPOSIA		\$13,750
NIH	CONFERENCE GRANTS	CONFERENCE ON PROTEOMICS & BIOINFORMATICS	R13RR021272-01	COSTELLO CATHERINE E - KEYSTONE SYMPOSIA		\$13,000
NIH	CONFERENCE GRANTS	NUCLEAR RECEPTORS: STEROID SISTERS	R13DK074313-01	MENDELSON CAROLE R - KEYSTONE SYMPOSIA		\$13,000
NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR NEURAL TRANSPLANTATION AND REPAIR	R13NS052013-01	SORTWELL CARYL E - RUSH UNIVERSITY MEDICAL CENTER		\$13,000
NIH	CONFERENCE GRANTS	BIOCOMPLEXITY VII: UNRAVELING THE FUNCTION AND KINETICS	R13GM075730-01	SCHNELL SANTIAGO - INDIANA UNIVERSITY BLOOMINGTON		\$12,749
NIH	CONFERENCE GRANTS	IASLC BIOLOGY AND PREVENTION OF LUNG CANCER WORKSHOP	R13CA117401-01	RIGAS JAMES R - DARTMOUTH COLLEGE		\$12,000
NIH	CONFERENCE GRANTS	WORKSHOPS ON VIRAL PATHOGENESIS AND ONCOGENESIS	R13CA095919-04	FAN HUNG Y - UNIVERSITY OF CALIFORNIA IRVINE		\$12,000

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NIH	CONFERENCE GRANTS	2005 CANNABINOID FUNCTION IN THE CNS GORDON CONFERENCE	R13DA019764-01	MACKIE KENNETH P. - GORDON RESEARCH CONFERENCES		\$12,000
NIH	CONFERENCE GRANTS	NEW PARADIGMS IN VASCULAR BIOLOGY: RENAL IMPLICATIONS	R13DK069394-01	SEDOR JOHN R. - CASE WESTERN RESERVE UNIVERSITY		\$12,000
NIH	CONFERENCE GRANTS	STEM CELLS	R13GM076902-01	VERFAILLIE CATHERINE M - KEYSTONE SYMPOSIA		\$12,000
NIH	CONFERENCE GRANTS	9TH INTERNATIONAL CONFERENCE ON ENVIRONMENTAL MUTAGENS	R13CA117404-01	HANAWALT PHILIP C. - ENVIRONMENTAL MUTAGEN SOCIETY		\$11,000
NIH	CONFERENCE GRANTS	36TH ANNUAL MEETING OF THE SOCIETY FOR LEUKOCYTE BIOLOGY	R13AI066887-01	EZEKOWITZ ALAN B - SOCIETY FOR LEUKOCYTE BIOLOGY		\$11,000
NIH	CONFERENCE GRANTS	CONFERENCE-HOST RESISTANCE/SUSCEPTABILITY/IMMUNOPATHOLOGY	R13AI066871-01	O'GARRA ANNE - KEYSTONE SYMPOSIA		\$11,000
NIH	CONFERENCE GRANTS	INNATE IMMUNITY	R13AI066892-01	GORDON SIAMON - KEYSTONE SYMPOSIA		\$11,000
NIH	CONFERENCE GRANTS	AUA/SBUR RES. CONF. - "INFLAMMATION IN PROSTATE DISEASES"	R13DK072715-01	NELSON WILLIAM G - AMERICAN UROLOGICAL ASSOCIATION		\$11,000
NIH	CONFERENCE GRANTS	14TH INTERNATIONAL HLA & IMMUNOGENETICS WORKSHOP (HIWS)	R13AI066863-01	HANSEN JOHN A - FRED HUTCHINSON CANCER RESEARCH CENTER		\$10,500
NIH	CONFERENCE GRANTS	2005 PHAGOCYTES GORDON CONFERENCE	R13AI066865-01	DINAUER MARY C - GORDON RESEARCH CONFERENCES		\$10,500
NIH	CONFERENCE GRANTS	CONFERENCE-CHEMOKINES AND CHEMOKINE RECEPTORS	R13AI066862-01	LUSTER ANDREW D - KEYSTONE SYMPOSIA		\$10,500
NIH	CONFERENCE GRANTS	2005 IMMUNOCHEMISTRY AND IMMUNOBIOLOGY GORDON CONFERENCE	R13AI066421-01	KORETZKY GARY A - UNIVERSITY OF PENNSYLVANIA		\$10,500
NIH	CONFERENCE GRANTS	1ST ANNUAL MEETING-OLIGONUCLEOTIDE THERAPEUTICS SOCIETY	R13CA117399-01	TUSCHL THOMAS - NEW YORK ACADEMY OF SCIENCES		\$10,000
NIH	CONFERENCE GRANTS	2005 CANCER MODELS AND MECHANISMS GORDON CONFERENCE	R13CA117423-01	PANDOLFI PIER PAOLO - GORDON RESEARCH CONFERENCES		\$10,000

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NIH	CONFERENCE GRANTS	AORTIC INTERNATIONAL MEETINGS	R13CA119920-01	MOHAMMED SULMA IBRAHIM - PURDUE UNIVERSITY WEST LAFAYETTE			\$10,000
NIH	CONFERENCE GRANTS	CANCER AND KINASES	R13CA117397-01	DRUKER BRIAN J - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE-HEMATOLOGICAL MALIGNANCIES	R13CA117424-01	SPECK NANCY A - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$10,000
NIH	CONFERENCE GRANTS	HIMT 10TH BIENNIAL INTERNATIONAL FORUM ON OVARIAN CANCER	R13CA110913-01	HAMILTON THOMAS C - FOX CHASE CANCER CENTER			\$10,000
NIH	CONFERENCE GRANTS	HYPOXIA AND DEVELOPMENT, PHYSIOLOGY AND DISEASE	R13CA117421-01	SIMON M. CELESTE - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	PUERTO RICANS AND CANCER: THE UNEQUAL BURDEN	R13CA115176-01	LOPEZ-ENRIQUEZ REYNOLD EUGENIO - UNIVERSITY OF PUERTO RICO MED SCIENCES			\$10,000
NIH	CONFERENCE GRANTS	RNAI AND RELATED PATHWAYS	R13CA117393-01	MELLO CRAIG C - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	THIRD INTERNATIONAL MDM2 WORKSHOP	R13CA117383-01	MOLL UTE M - STATE UNIVERSITY NEW YORK STONY BROOK			\$10,000
NIH	CONFERENCE GRANTS	2005 CARBOHYDRATES GORDON CONFERENCE	R13RR021723-01	BOONS GEERT-JAN - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	2005 GRADIENT SENSING AND DIRECTED CELL MIGRATION GRC	R13AI065115-01	DEVREOTES PETER N - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	BIENNIAL SYMPOSIUM ON H.DUCREYI PATHOGENESIS & CHANCROID	R13AI065183-01	SPINOLA STANLEY M - INDIANA UNIV-PURDUE UNIV AT INDIANAPOLIS			\$10,000
NIH	CONFERENCE GRANTS	2005 MECHANISMS OF MEMBRANE TRANSPORT GORDON CONFERENCE	R13DK071453-01	STROUD ROBERT M - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	31ST PEDIATRIC NEPHROLOGY SEMINAR	R13DK067507-01A1	STRAUSS JOSE - UNIVERSITY OF MIAMI SCHOOL OF MEDICINE			\$10,000
NIH	CONFERENCE GRANTS	CONFERENCE ON ASSESSING QUALITY OF CARE FOR DIABETES	R13DK074335-01	KERR EVE A - UNIVERSITY OF MICHIGAN AT ANN ARBOR			\$10,000

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NIH	CONFERENCE GRANTS	DIABETES MELLITUS AND THE CONTROL OF ENERGY METABOLISM	R13DK074300-01	CORVERA SILVIA - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE: GLUCOSE TRANSPORTER BIOLOGY	R13DK072708-01	MCGRAW TIMOTHY E - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$10,000
NIH	CONFERENCE GRANTS	NEUROHYPOPHYSIAL HORMONES: FROM GENOMICS THROUGH DISEASE	R13DK071451-01	FRANK MARTIN - AMERICAN PHYSIOLOGICAL SOCIETY			\$10,000
NIH	CONFERENCE GRANTS	NUCLEAR RECEPTORS: ORPHAN BROTHERS	R13DK074303-01	GIGUERE VINCENT - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	PANCREATIC ISLETS: FROM DEVELOPMENT TO TRANSPLANTATION	R13DK074311-01	POWERS ALVIN C - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	TOWARDS UNDERSTANDING ISLET BIOLOGY	R13DK074221-01	AGUILAR-BRYAN LYDIA - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	2005 MOLECULAR MEMBRANE BIOLOGY GORDON CONFERENCE	R13GM074280-01	SCHMID SANDRA L - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	CONFERENCE ON ROLES OF RNA IN GENE REGULATION	R13GM073291-01	HANNON GREGORY J - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	CONFERENCE ON SYSTEMS & BIOLOGY	R13GM073377-01	VIDAL MARC - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	IAS/PARK CITY MATH INSTITUTE UNDERGRADUATE SUMMER SCHOOL	R13GM075668-01	GRIFFITHS PHILLIP A - INSTITUTE FOR ADVANCED STUDY			\$10,000
NIH	CONFERENCE GRANTS	ISMB 2005 CONF. SUPPORT FOR STUDENTS & YOUNG SCIENTISTS	R13GM075666-01	BOURNE PHILIP E - UNIVERSITY OF CALIFORNIA SAN DIEGO			\$10,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON COMPLEXITY IN ACUTE ILLNESS	R13GM072437-02	CLERMONT GILLES - UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$10,000
NIH	CONFERENCE GRANTS	MICROFLUIDICS, PHYSICS AND CHEMISTRY OF GORDON CONFERENCE	R13GM075550-01	LOCASCIO LAURIE E - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	UNDERSTAND COMPLEX SYSTEMS 2005: COMPUTA COMPLEX /INFORM	R13GM075725-01	HUBER ALFRED W - UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN			\$10,000
NIH	CONFERENCE GRANTS	CONFERENCE ON CENTRAL NERVOUS SYSTEM INFLAMMATION	R13NS050910-01	BARNUM SCOTT R - KEYSTONE SYMPOSIA			\$10,000

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NIH	CONFERENCE GRANTS	SEX AND GENE EXPRESSION	R13NS052009-01	SANDBERG KATHRYN L - GEORGETOWN UNIVERSITY			\$10,000
NIH	CONFERENCE GRANTS	TRIGEMINAL NEURALGIA ASSOCIATION 5TH NATIONAL CONFERENCE	R13NS051122-01	RHOTON ALBERT L - TRIGEMINAL NEURALGIA ASSOCIATION			\$10,000
NIH	CONFERENCE GRANTS	ANNUAL SABIN COLLOQUIUM ON CANCER VACCINES AND IMMUNOTHERAPY	R13CA117408-01	SHEPHERD H R - ALBERT B. SABIN VACCINE INSTITUTE			\$9,000
NIH	CONFERENCE GRANTS	ANTI-ANGIOGENESIS/DRUGS IN TUMORS--BENCH /BEDSIDE & BACK	R13CA119852-01	JAIN RAKESH K. - AMERICAN ASSOCIATION FOR CANCER RESEARCH			\$9,000
NIH	CONFERENCE GRANTS	CANCER, PROTEASES AND THE MICROENVIRONMENT	R13CA119825-01	DECLERCK YVES A - AMERICAN ASSOCIATION FOR CANCER RESEARCH			\$9,000
NIH	CONFERENCE GRANTS	3RD ORTHOMYXOVIRUSES RESEARCH CONFERENCE	R13AI066861-01	MCCULLERS JONATHAN A - ST. JUDE CHILDRENS RESEARCH HOSPITAL			\$9,000
NIH	CONFERENCE GRANTS	PROTEIN TRANSPORT ACROSS CELL MEMBRANES GORDON CONFERENCE 2005	R13GM075551-01	DALBEY ROSS E - GORDON RESEARCH CONFERENCES			\$9,000
NIH	CONFERENCE GRANTS	STRUCTURAL ANALYSIS OF SUPRAMOLEC ASSEMBLIES BY HYBRID METHOD	R13GM075723-01	HANEIN DORIT - BURNHAM INSTITUTE FOR MEDICAL RESEARCH			\$8,500
NIH	CONFERENCE GRANTS	ADVANCES IN OPTICS FOR BIOTECHNOLOGY, MEDICINE	R13CA115171-01	NTZIACHRISTOS VASILIS - ENGINEERING CONFERENCES INTERNATIONAL			\$8,000
NIH	CONFERENCE GRANTS	CHEMISTRY OF MUTAGENESIS	R13CA117789-01	SPRATT THOMAS E - PENNSYLVANIA STATE UNIV HERSHEY MED CTR			\$8,000
NIH	CONFERENCE GRANTS	10TH INTERNATIONAL CMV WORKSHOP	R13AI062202-01	ADLER STUART P - VIRGINIA COMMONWEALTH UNIVERSITY			\$8,000
NIH	CONFERENCE GRANTS	FALL SBUR MEETING: MEMBRANE BIOLOGY IN BASIC UROLOGY	R13DK072709-01	CHAI KARL X - UNIVERSITY OF CENTRAL FLORIDA			\$8,000
NIH	CONFERENCE GRANTS	2005 CELL BIOLOGY OF METALS GORDON CONFERENCE	R13GM074269-01	WINGE DENNIS R. - GORDON RESEARCH CONFERENCES			\$8,000

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NIH	CONFERENCE GRANTS	2005 CHRONOBIOLOGY GORDON RESEARCH CONFERENCE	R13NS02032-01	GILLETTE MARTHA U - GORDON RESEARCH CONFERENCES			\$7,997
NIH	CONFERENCE GRANTS	ASILOMAR CHROMATIN AND CHROMOSOMES CONFERENCE	R13CA119824-01	MC MURRAY CYNTHIA THERESE - MAYO CLINIC COLL OF MEDICINE, ROCHESTER			\$7,000
NIH	CONFERENCE GRANTS	CONFERENCE ON CANCER AND DEVELOPMENT	R13CA112977-01	SCOTT MATTHEW P - KEYSTONE SYMPOSIA			\$7,000
NIH	CONFERENCE GRANTS	CONFERENCE ON CELLULAR SENESCENCE AND CELL DEATH	R13CA112922-01	GREEN DOUGLAS R - KEYSTONE SYMPOSIA			\$7,000
NIH	CONFERENCE GRANTS	CONFERENCE ON TUMOR INDUCTION AND PROGRESSION	R13CA113258-01	BISSELL MINA J - KEYSTONE SYMPOSIA			\$7,000
NIH	CONFERENCE GRANTS	MOLECULAR & CELLULAR BIOENERGETICS GORDON CONF. 2005	R13GM074281-01	KANE PATRICIA M - GORDON RESEARCH CONFERENCES			\$7,000
NIH	CONFERENCE GRANTS	CLEARANCE OF DYING CELLS BY PHAGOCYTES GORDON CONFERENCE	R13CA115000-01	SCHLEGEL ROBERT A - GORDON RESEARCH CONFERENCES			\$6,500
NIH	CONFERENCE GRANTS	FASEB CONFERENCE - PKD MECHANISMS AND CLINICAL IMPACT	R13DK072706-01	GUAY-WOODFORD LISA M - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$6,000
NIH	CONFERENCE GRANTS	UROTHELIAL CELL PHYSIOLOGY IN NORMAL AND DISEASE STATES	R13DK072899-01	SABAN RICARDO - UNIVERSITY OF OKLAHOMA HLTH SCIENCES CTR			\$6,000
NIH	CONFERENCE GRANTS	CELL OSMOREGULATION: SENSORS, TRANSPORTERS & REGULATORS	R13DK071376-01	BOLEN DAVID W - GORDON RESEARCH CONFERENCES			\$6,000
NIH	CONFERENCE GRANTS	A BLACK MAN CAN...FIGHT PROSTATE CANCER	R13CA119832-01	WILLIAMS-BROWN SHANITA D - MOREHOUSE SCHOOL OF MEDICINE			\$5,000
NIH	CONFERENCE GRANTS	ANNUAL WESTERN NORTH CAROLINA CANCER CONFERENCE	R13CA119827-01	THOMAS CHARLES C - COMMUNITY CANCER EDUCATION, INC.			\$5,000
NIH	CONFERENCE GRANTS	CONFERENCE ON CHROMATIN MODIFICATION PATHWAYS	R13CA112925-01	KOUZARIDES TONY - KEYSTONE SYMPOSIA			\$5,000
NIH	CONFERENCE GRANTS	INTEGRATING REHABILITATION AND PALLIATION IN CANCER CARE	R13CA115166-01	HAUSER JOSHUA M - NORTHWESTERN UNIVERSITY			\$5,000

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NIH	CONFERENCE GRANTS	MECHANISMS AND TREATMENT OF CANCER-RELATED SYMPTOMS CONF	R13CA115170-01	CLELAND CHARLES S - UNIVERSITY OF TEXAS MD ANDERSON CAN CTR			\$5,000
NIH	CONFERENCE GRANTS	SYMPOSIUM ON STRUCTURAL BIOLOGY OF DNA REPAIR	R13CA117398-01	KISKER CAROLINE F - STATE UNIVERSITY NEW YORK STONY BROOK			\$5,000
NIH	CONFERENCE GRANTS	THE ROLE OF TELOMERES AND TELOMERASE IN CANCER	R13CA113094-01	SHAY JERRY WILLIAM - AMERICAN ASSOCIATION FOR CANCER RESEARCH			\$5,000
NIH	CONFERENCE GRANTS	TOBACCO CARCINOGENESIS	R13CA117411-01	HECHT STEPHEN S - UNIVERSITY OF MINNESOTA TWIN CITIES			\$5,000
NIH	CONFERENCE GRANTS	FOURTH ANNUAL NATIONAL HEALTH COMMUNICATION CONFERENCE	R13CA119596-01	FALLON HAROLD J - AMERICAN COLLEGE OF PHYSICIANS FDN			\$5,000
NIH	CONFERENCE GRANTS	ANNUAL MEETING OF THE AM SOC FOR INVESTIGATIVE PATHOLOGY	R13A065114-01	FURIE MARTHA B - AMERICAN SOCIETY/INVESTIGATIVE PATHOLOGY			\$5,000
NIH	CONFERENCE GRANTS	SIXTH INTERNATIONAL CONFERENCE ON LEGIONELLA	R13A065125-01	CIANCIO OTTO NICHOLAS P - NORTHWESTERN UNIVERSITY			\$5,000
NIH	CONFERENCE GRANTS	TWENTY THIRD FUNGAL GENETICS CONFERENCE	R13A065130-01	ORBACH MARC J - UNIVERSITY OF ARIZONA			\$5,000
NIH	CONFERENCE GRANTS	DIABETES RESEARCH: FROM CELL BIOLOGY TO CELL THERAPY	R13DK072701-01	KANDEEL FOUAD R - CITY OF HOPE/BECKMAN RESEARCH INSTITUTE			\$5,000
NIH	CONFERENCE GRANTS	2005 PROTEINS GORDON CONFERENCE	R13GM074552-01	RATH VIRGINIA L - GORDON RESEARCH CONFERENCES			\$5,000
NIH	CONFERENCE GRANTS	ASCB SUMMER MEETING: NUCLEAR ARCHITECTURE AND DISEASE	R13GM075351-01	WILSON KATHERINE L - AMERICAN SOCIETY FOR CELL BIOLOGY			\$5,000
NIH	CONFERENCE GRANTS	BACTERIAL LOCOMOTION AND SIGNAL TRANSDUCTION VIII MTG.	R13GM073239-01	KADNER ROBERT J - UNIVERSITY OF VIRGINIA CHARLOTTESVILLE			\$5,000
NIH	CONFERENCE GRANTS	CONFERENCE MODELING OF PROTEIN INTERACTIONS IN GENOMES	R13GM075726-01	VAJDA SANDOR - BOSTON UNIVERSITY			\$5,000
NIH	CONFERENCE GRANTS	CONFERENCE ON FRONTIERS OF NMR IN MOLECULAR BIOLOGY	R13GM073374-01	SYKES BRIAN DOUGLAS - KEYSTONE SYMPOSIA			\$5,000

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NIH	CONFERENCE GRANTS	EXPERIMENTAL NMR CONFERENCE	R13GM074361-01	BROWN TRUMAN R. - COLUMBIA UNIVERSITY HEALTH SCIENCES			\$5,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE-MECHANISM AND REGULATION OF PROKARYOTIC TRANSCRIPTION	R13GM075724-01	GROSS CAROL A - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$5,000
NIH	CONFERENCE GRANTS	GORDON RES. CONF. SIGNAL TRANSDUCTION WITHIN THE NUCLEUS	R13GM074550-01	RABEN DANIEL M. - GORDON RESEARCH CONFERENCES			\$5,000
NIH	CONFERENCE GRANTS	NUCLEIC ACIDS GORDON RESEARCH CONFERENCE 2005	R13GM074272-01	FEDOR MARTHA J. - GORDON RESEARCH CONFERENCES			\$5,000
NIH	CONFERENCE GRANTS	STRUCTURAL GENOMICS	R13GM075727-01	ARROWSMITH CHERYL H. - KEYSTONE SYMPOSIA			\$5,000
NIH	CONFERENCE GRANTS	UPPSALA ECD-ETD CONFERENCE	R13GM077029-01	GOODLETT DAVID ROBINSON - UNIVERSITY OF WASHINGTON			\$5,000
NIH	CONFERENCE GRANTS	FOURTEENTH CONVERSATION: BIOMOLECULAR STEREODYNAMICS	R13GM075346-01	SARMA RAMASWAMY H. - STATE UNIVERSITY OF NEW YORK AT ALBANY			\$5,000
NIH	CONFERENCE GRANTS	MOLECULAR AND CELLULAR BIOLOGY OF LIPIDS	R13GM062900-03	MARTIN CHARLES E. - GORDON RESEARCH CONFERENCES			\$5,000
NIH	CONFERENCE GRANTS	ASN WORKSHOP "IN VIVO MR TRACKING OF STEM CELLS IN THE CNS" (R13)	R13NS054461-01	BULTE JEFF W. - JOHNS HOPKINS UNIVERSITY			\$5,000
NIH	CONFERENCE GRANTS	INTRACEREBRAL HEMORRHAGE CONFERENCE	R13NS052115-01	HOFF JULIAN T. - UNIVERSITY OF MICHIGAN AT ANN ARBOR			\$5,000
NIH	CONFERENCE GRANTS	THE BRAIN TUMOR EPIDEMIOLOGY CONSORTIUM FALL '05 MEETING	R13NS054479-01	DAVIS FAITH B. - CENTRAL BRAIN TUMOR REGISTRY OF THE U.S.			\$5,000
NIH	CONFERENCE GRANTS	PHARMGKB EXPERIMENTAL BIOLOGY WORKSHOP 2005	R13GM074553-01	TRACY TIMOTHY S. - AMERICAN SOCIETY FOR PHARMACOLOGY EXP TH			\$4,750
NIH	CONFERENCE GRANTS	KIDNEY'S FAIL: TRANSLATING BASIC MECHANISMS INTO THERAPIES	R13DK074301-01	SCHNAAPER H WILLIAM - CHILDREN'S MEMORIAL HOSPITAL (CHICAGO)			\$4,000

NIH	CONFERENCE GRANTS	METALS IN BIOLOGY & GRADUATE RES SEMINAR GORDON CONFER	R13GM074563-01	DAWSON JOHN H - GORDON RESEARCH CONFERENCES		\$4,000
NIH	CONFERENCE GRANTS	ADVANCES IN THE UNDERSTANDING AND TREATMENT OF MELANOMA	R13CA117400-01	HWU PATRICK - KEYSTONE SYMPOSIA		\$3,000
NIH	CONFERENCE GRANTS	CONFERENCE ON HORMONAL REGULATION OF TUMORIGENESIS	R13CA112924-01	WEIGEL NANCY LYNN - KEYSTONE SYMPOSIA		\$3,000
NIH	CONFERENCE GRANTS	CONFERENCE ON MOLECULAR TARGETS FOR CANCER THERAPY	R13CA112983-01	COURTNEIDGE SARA A - KEYSTONE SYMPOSIA		\$3,000
NIH	CONFERENCE GRANTS	CONFERENCE ON ROLES OF TGF- BETA IN DISEASE PATHOGENESIS	R13CA112923-01	SPORN MICHAEL B - KEYSTONE SYMPOSIA		\$3,000
NIH	CONFERENCE GRANTS	2005 PLANT METABOLIC ENGINEERING GORDON RES. CONFERENCE	R13GM074266-01	WURTZEL ELEANORE T - GORDON RESEARCH CONFERENCES		\$3,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON BIOLOGICAL INORGANIC CHEMISTRY	R13GM075667-01	COUCOUVANIS DIMITRI N - UNIVERSITY OF MICHIGAN AT ANN ARBOR		\$2,000
NIH	CONFERENCE GRANTS	INTERNATIONAL WORKSHOP ON AUTOANTIBODIES & AUTOIMMUNITY	R13AI068372-01	CHAN EDWARD K - UNIVERSITY OF FLORIDA		\$1,000
NIH Total =						\$4,552,661

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Substance Abuse and Mental Health Services Administration (SAMHSA)					
SAMHSA	SAMHSA Emergency Response - Project Recovery - Florida Hurricane Disaster	SM00202-01	Florida Dept of Children & Families	N	Y
Hurricane Katrina					
SAMHSA Total =					\$11,000,000

FY 2006 Non-Competitive Grants

OPDIV	Program Title	Grant Title	Grant Award #	Grantee Name	Unsolicited (Y/N)	Sole Source / Limited Competition (Y/N)	Award Amount
Administration for Children and Families (ACF)							
ACF	ACYF/Child Care Bureau	Child Care Research Partnerships	90YE0088	Northwestern University	N	LC-Y	\$27,506
ACF	ACYF/Child Care Bureau	Child Care Research Partnerships	90YE0090	University of Maryland	N	LC-Y	\$24,009
ACF	ACYF/Child Care Bureau	Child Care Research Partnerships	90YE0089	Cornell University	N	LC-Y	\$23,433
ACF	ADD	University Affiliated Programs	90DD0593	Oregon Health & Science University, Child Development & Rehabilitation Center	N	SS Program Expansion Supplement - Y	\$65,000
ACF	OCSE	Urban & Rural Economic Development	90EE0720	Hall Neighborhood House	N	SS-Y	\$663,263
ACF	OCSE	Assets for Independence Demonstration	90EI0015	Albion Brighton Community Development Corporation	N	SS-Y	\$116,115
ACF	OCSE	Assets for Independence Demonstration	90EI0048	Non-Profit Assistance Corporation	N	SS-Y	\$113,000
ACF	OCSE	Assets for Independence Demonstration	90EI0060	City of San Antonio	N	SS-Y	\$15,000
ACF	OCSE	SIP	90FI0086	TX Family Service Association			\$200,000
ACF	OCSE	SIP	90FI0087	Child and Family Resource Council, Kent County, MI			\$199,323
ACF	OCSE	SIP	90FI0085	Center for Policy Research, Denver, CO			\$198,664
ACF	OCSE	Section 1115	90FD0111	CO Department of Human Services			\$174,845
ACF	OCSE	Section 1115	90FD0114	CA Department of Child Support Services			\$150,000
ACF	OCSE	Section 1115	90FD0115	CO Department of Human Services			\$150,000
ACF	OCSE	Section 1115	90FD0116	MD Department of Human Resources			\$135,000
ACF	OCSE	Section 1115	90FD0119	DC Office of the Attorney General			\$135,000
ACF	OCSE	Section 1115	90FD0105	WI Department of Workforce Development			\$108,400
ACF	OCSE	Section 1115	90FD0107	WA State Department Social and Health Services			\$108,400

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ACF	OCSE	Section 1115	90FD0110	HI Child Support Enforcement Agency		\$108,400
ACF	OCSE	Section 1115	90FD0113	TX Office of Attorney General		\$108,400
ACF	OCSE	Section 1115	90FD0109	MD Department of Human Resources		\$102,421
ACF	OCSE	Section 1115	90FD0108	TN Department of Human Services		\$101,427
ACF	OCSE	SIP	90FD0070	The Fathers' Support Center, St. Louis, MO		\$100,000
ACF	OCSE	SIP	90FD0076	Families Under Urban and Social Attack, TX		\$100,000
ACF	OCSE	SIP	90FD0077	AL Child Abuse and Neglect Prevention Board, The Children's Trust Fund		\$100,000
ACF	OCSE	SIP	90FD0083	Philadelphia, PA Housing Authority		\$100,000
ACF	OCSE	SIP	90FD0084	Christian Community Council, Albany, LA		\$100,000
ACF	OCSE	SIP	90FD0071	Michigan State University		\$99,996
ACF	OCSE	SIP	90FD0069	South Baton Rouge Christian Children's Foundation of LA		\$99,962
ACF	OCSE	Child Support Enforcement Demonstration and Special Projects - Area 2	90FD0048	Community Services for Children, Incorporated	N	\$99,227
ACF	OCSE	Section 1115	90FD0118	ND Department of Human Services		\$75,000
ACF	OCSE	Section 1115	90FD0117	NE Health and Human Services, CSE		\$51,005
ACF	OCSE	SIP	90FD0081	M1 3rd Judicial Circuit Court		\$37,500
ACF	OCSE	SIP	90FD0082	National Council of Juvenile and Family Court Judges, NV		\$37,500
ACF	OCSE	SIP	90FD0072	TX Office of the Attorney General		\$25,000
ACF	OCSE	SIP	90FD0074	Georgia State University		\$25,000
ACF	OCSE	SIP	90FD0075	M1 Department of Community Health		\$24,805
ACF	OCSE	SIP	90FD0073	Center for Policy Research		\$24,730
ACF	OCSE	OFA	90YED0075	Oregon State University	N	\$101,774
					SS Program Expansion Supplement - Y	

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ACF	Office of Policy, Research and Evaluation	Home Visitors	90PH0014	The University of North Carolina at Chapel Hill	N	LC-Y	\$100,000
ACF	Office of Policy, Research and Evaluation	Home Visitors	90PH0011	Westat, Inc.	N	LC-Y	\$99,869
ACF	Office of Policy, Research and Evaluation	Home Visitors	90PH0010	Board of Regents of the University of Wisconsin System	N	LC-Y	\$99,852
ACF	Office of Policy, Research and Evaluation	Home Visitors	90PH0013	Washington University	N	LC-Y	\$99,770
ACF	Office of Policy, Research and Evaluation	Home Visitors	90PH0012	University of Colorado at Denver and Health Sciences Center	N	LC-Y	\$99,462
ACF	Office of Policy, Research and Evaluation	Home Visitors	90PH0015	University of Iowa	N	LC-Y	\$81,135
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0134	Texas Health & Human Services Commission	N	LC-Y	\$781,465
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0136	State of Wisconsin Department of Workforce Development	N	LC-Y	\$600,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0122	Florida Department of Children & Family Services	N	LC-Y	\$450,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0135	State of Washington	N	LC-Y	\$350,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0131	NY State Office of Temporary & Disability Assistance	N	LC-Y	\$345,844
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0126	Massachusetts Office for Refugees & Immigrants	N	LC-Y	\$335,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0128	Minnesota Department of Human Services	N	LC-Y	\$319,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0124	Illinois Department of Human Services	N	LC-Y	\$250,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0120	Arizona Department of Economics Security	N	LC-Y	\$215,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0127	Department of Human Services	N	LC-Y	\$200,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0132	Pennsylvania Department of Public Welfare	N	LC-Y	\$175,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0121	State of Connecticut	N	LC-Y	\$175,000
ACF	Office of Refugee Resettlement	Targeted Assistance	90RT0129	Missouri Department of Social Services	N	LC-Y	\$150,315

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Administration for Healthcare Research and Quality (AHRQ)						
AHRQ	BUILDING RESEARCH INFRASTRUCTURE AND CAPACITY PROGRAM	Developing Practice Improvement Research	HS015803-01	UNIVERSITY OF SOUTHERN MAINE	N	Y
AHRQ	BUILDING RESEARCH INFRASTRUCTURE AND CAPACITY PROGRAM	Craigton Health Services Research Development Project	HS015816-01	CRAIGHTON UNIVERSITY	N	Y
AHRQ	BUILDING RESEARCH INFRASTRUCTURE AND CAPACITY PROGRAM	Arkansas Consortium for Health Services Research	HS015878-01	UNIVERSITY OF ARKANSAS MED SCIS LTL ROCK	N	Y
AHRQ	BUILDING RESEARCH INFRASTRUCTURE AND CAPACITY PROGRAM	Building the West Virginia CoHORTS Center	HS015930-01	WEST VIRGINIA UNIVERSITY	N	Y
AHRQ	BUILDING RESEARCH INFRASTRUCTURE AND CAPACITY PROGRAM	Great Plains Institute for Rural Health Services Resear*	HS015931-01	UNIVERSITY OF NORTH DAKOTA	N	Y
AHRQ	NATIONAL RESEARCH SERVICE AWARD INDIVIDUAL POSTDOCTORAL FELLOWS	START Triage: Improving a 'trial-and-true' methodology.	HS015768-01A1	UNIVERSITY OF CALIFORNIA IRVINE	N	Y
AHRQ	NIH PREDOCTORAL FELLOWSHIP AWARD FOR MINORITY STUDENTS	Minority Predoctoral Fellowship Program	HS016452-01	UNIVERSITY OF PENNSYLVANIA	N	Y
AHRQ	RUTH L KIRSCHSTEIN NATIONAL RESEARCH SERVICE AWARD FOR INDIVIDUAL POSTDOCTORAL FELLOWS	Assessing Anticoagulation Therapy Management Services	HS016275-01	UNIVERSITY OF MARYLAND BALTIMORE	N	Y
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Fourth Annual National Health Communication Conference	HS016185-01	AMERICAN COLLEGE OF PHYSICIANS FDN		
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	The New Practice Model for Primary Care: Setting a Research and Policy Agenda	HS016310-01	UNIVERSITY OF CALIFORNIA SAN FRANCISCO		
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT	Graduate Medical Education and Quality of Care: Developing a Research Agenda	HS016312-01	ASSOCIATION OF AMERICAN MEDICAL COLLEGES		

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AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Impact of direct to consumer(DTC)advertising of drugs	HS016309-01	NATIONAL CONSUMERS LEAGUE			\$24,120
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Global Government Health Partners Forum 2006 "The Breaking Point: Human Resources	HS016499-01	EMORY UNIVERSITY			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	1st National Summit on Primary Care Emergency Preparedness	HS016593-01	PRIMARY CARE DEVELOPMENT CORPORATION			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	National Quality Forum - Annual Meeting	HS016597-01	NATIONAL QUALITY FORUM			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	2006 Medical Leadership Building Bridges Conference	HS016602-01	AMERICA'S HEALTH INSURANCE PLANS			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Meeting the Nation's Needs for Personal Assistance Services Conference	HS016608-01	UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Primary Care Research Methods and Statistics Conference, Dec 1-3, 2006	HS016444-01	UNIVERSITY OF TEXAS HLTH SCI CTR SAN ANT			\$49,909
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Better Decisions, Better Care: Advancing decision support to improve health care	HS016486-01	RHODE ISLAND HOSPITAL (PROVIDENCE, RI)			\$49,813
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Measuring Quality of Care and Patient Safety: Problems in Use and Interpretation	HS016493-01	TEXAS A&M UNIVERSITY HEALTH SCIENCE CTR			\$49,565
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Medication Error Reporting Systems: Challenges, Lessons, Future Direction	HS016515-01	U.S. PHARMACOPEIA			\$49,000

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AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Conference on Medical Surge Capacity	HS016449-01	HENRY M. JACKSON FDN FOR THE ADV MIL/MED		\$45,552
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Conference to Improve Outcomes in Pediatric Trauma Care	HS016431-01	UNIVERSITY OF WASHINGTON		\$45,497
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Research Ethics in Emergency Medical Services: Working conference for development	HS016375-01A1	NATIONAL ASSOCIATION OF EMS PHYSICIANS		\$40,147
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Patient Safety Consortium National Conference	HS016456-01	STANFORD UNIVERSITY		\$40,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Health Care Policy and Practice: Promoting Environments for Quality Care	HS016436-01	UNIVERSITY OF MICHIGAN AT ANN ARBOR		\$39,980
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Asthma Education Conference for Tribal Health Officers Serving the Aberdeen Area	HS016435-01	UNIVERSITY OF IOWA		\$39,183
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Transforming Medical Education to Prepare Physicians for Practice	HS016595-01	AMERICAN MEDICAL ASSOCIATION		\$37,397
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Developing a LTC Patient Safety Research Agenda	HS016609-01	AMERICAN MEDICAL DIRECTORS ASSOC FDN		\$35,500
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	10th International Fragile X Conference	HS016448-01	NATIONAL FRAGILE X FOUNDATION		\$25,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Workshop on Systematic Reviews of Diagnostic Tests	HS016490-01	BROWN UNIVERSITY		\$24,625

FY 2006 Non-Competitive Grants

AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Consensus Summit Conference on Patient Safety in the Office Based Surgery Setting	HS016453-01	AMRCN ASSOC ACCRED AMBU SURG FAC ED FDN		\$22,250
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Building Bridges: Interdisciplinary Paths to Palliative & End-of-Life Care	HS016509-01	UNIVERSITY OF SOUTH FLORIDA		\$19,000
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Center for Excellence in Health Care Journalism National Conference	HS016284-01	CENTER FOR EXCELLENCE IN HLTH CARE JOURN		\$50,000
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Georgia Hospital Association: Patient Safety Improvement Corps (GHAPSC)	HS016288-01	GEORGIA HOSPITAL ASSOCIATION RES/EDU FDN		\$50,000
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Child Abuse Recognition, Research, Education Translation (CARRET) Conference	HS016359-01	AMERICAN ACADEMY OF PEDIATRICS		\$50,000
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	HMO Research Network Conference	HS016363-01	UNIV OF MASSACHUSETTS MED SCH WORCESTER		\$49,560
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Upper Midwest Long-Term Care Quality Summit	HS016302-01	UNIVERSITY OF ST. THOMAS		\$49,533
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Increasing the Impact of Maternal and Neonatal Health Systematic Reviews	HS016273-01	TULANE UNIVERSITY OF LOUISIANA		\$49,512
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Using Clinical Guidelines to Improve the Care of Older Persons Conference	HS016371-01	UNIVERSITY OF MINNESOTA TWIN CITIES		\$45,968
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	17th ANNUAL HEALTH ECONOMICS CONFERENCE	HS016352-01	MEDICAL UNIVERSITY OF SOUTH CAROLINA		\$36,000
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Promoting Quality of Care for Publicly Insured Children	HS016360-01	NATL INITIATIVE/CHILDREN'S HLTHCARE QUAL		\$35,345
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Child Health Services Research Meeting	HS016292-01	ACADEMYHEALTH		\$35,000
AHRQ	SMALL GRANTS PROGRAM FOR CONFERENCE SUPPORT	Spinal Cord Dysfunction Research and Education Knowledge Translation Conference	HS016305-01	PARALYZED VETERANS OF AMERICA		\$24,850

FY 2006 Non-Competitive Grants

Administration on Aging (AoA)					
AoA	(Unsolicited)	Preparing the Aging Network for the Administration on Aging Choices for Independence	90AM3126	National Association of Area Agencies on Aging	
				Y	Y
					\$364,839
AoA Total =					\$364,839

FY 2006 Non-Cooperative Grants

Centers for Disease Control and Prevention (CDC)						
CDC	A Grant to Establish a Center for the Prevention and Control of Risk Factors for Chronic Diseases	U01 MN000001	Nashville General Hospital	N	Y	\$1,000,000
CDC	Assessment of the Health Effects from Exposure to Volcanic Emission	R01 EH000111	Hawaii DOH	N	Y	\$77,703
CDC	Building Health-Sector Capacity for Planning, Coordination, Monitoring, Evaluation and Mobilization of Resources in Support of Decentralized HIV/AIDS Interventions in the Republic of Cote d'Ivoire under PEPFAR	U2G/PS/00632	Ministry of Health and Public Hygiene	N	Y	\$622,000
CDC	CA with the Ministry of Public Health in the Kingdom of Thailand	U19 GH000004	Thailand Ministry Of Public Health	N	Y	\$4,111,103
CDC	CA with the Ministry of Public Health in the Kingdom of Thailand	U19 GH000004-S1	Thailand Ministry Of Public Health	N	Y	\$1,500,003
CDC	Capacity Building Asst. For Global HIV/AIDS Program Development Through Technical Assistance collaboration with the National Association of State and Territorial AIDS Directors	U62/PS624596	National Association of State and Territorial AIDS Directors (NASTAD)	N	Y	\$1,518,000
CDC	Control of Plague in Uganda	U01CD00393	Uganda Virus Research Institute	N	Y	\$23,400
CDC	Cooperative Agreement for the National Preparedness Leadership Initiative (NPLI) to Advance the Practice of Meta-leadership in Government	U90TP000101	Harvard University (Sch Of Public Hlth)	N	Y	\$956,093

FY 2006 Non-Cooperative Grants

CDC	Cooperative Agreement with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Through the World Health Organization (WHO) as Bona Fide Agent	U62PS025108	World Health Organization/UNAIDS	N	Y	\$2,579,000
CDC	Cooperative Agreement with the Kenya Medical Research Institute (KEMRI)	U19C0000323	Kenya Medical Research Institute (KEMRI)	N	Y	\$14,573,622
CDC	Coordinate & Implement HIV/AIDS Surveillance, Capacity Building Activities to Supp	U2G/PS000447	National AIDS Commission	N	Y	\$300,000
CDC	Coordinate & Implement HIV/AIDS Surveillance, Capacity Building Activities to Supp	U2G/PS000447	National AIDS Commission	N	Y	\$300,000
CDC	Coordination of Activities between the CDC's National Immunization Program and the State & Territorial Health Officials (ASTHO)	U38 325056	Association of State and Territorial Health Officials (ASTHO)	N	Y	\$274,999
CDC	Development and Support of a National Public Health Information Infrastructure	U38 HM000022	Council Of State Governments	N	Y	\$646,080
CDC	Development of Influenza Surveillance network	U51C000394	Ministry of Health	N	Y	\$564,500
CDC	Diabetes Prevention and Control Project in the Americas	U01 DP000604	Pan American Health Organization	N	Y	\$539,000
CDC	Engaging State and Local Emergency Management Agencies to Improve States Ability to Respond to Bioterrorism	U90 TP000100	Council Of State Governments	N	Y	\$128,340
CDC	Enhancing Communicable Disease Surveillance in the African region	U51C000421	WHO/AFRO	N	Y	\$125,000
CDC	Enhancing Communicable Disease Surveillance in the African Region	U51 C000421	World Health Organization--Afro	N	Y	\$125,000

FY 2006 Non-Competitive Grants

CDC	Environmental Health Academic Programs	Environmental Health Academic Programs	U50/CCU024903	Association of Environmental Academic Programs	N	Y	\$180,000
CDC	Environmental Health Education & Monitoring Activities	Environmental Health Education & Monitoring Activities	TS 000063	State of Oklahoma DOH	N	Y	\$160,550
CDC	Expanding and Integrating HIV Care in the Republic of Kenya under the President's Emergency Plan for AIDS Relief	Expanding and Integrating HIV Care in Kenya	U2GPS000644	National AIDS STI Control Program	N	Y	\$5,700,000
CDC	Expansion of HIV/AIDS STD Surveillance, Care and Prevention activities in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	Expansion of HIV/AIDS STD Surveillance, Care and Prevention activities in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	U2GPS000647	Ministry of Health and Child Welfare	N	Y	\$500,000
CDC	Expansion of HIV/AIDS STD Surveillance, Care and Prevention activities in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	Expansion of HIV/AIDS STD Surveillance, Care and Prevention activities in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	U2GPS000647	Ministry of Health and Child Welfare	N	Y	\$500,000
CDC	Implementation of Programs to Improve the Management of Care for HIV/AIDS, Sexually Transmitted Infection and Tuberculosis in the Eastern Province of the Republic of Zambia under PEPFAR	Activities within this Project include the implementation of Programs to improve	U2GPS000641	Eastern Provincial Health Office	N	Y	\$1,015,000
CDC	Implementation of Programs to Improve the Management of Care for HIV/AIDS, Sexually Transmitted Infection and Tuberculosis in the Eastern Province of the Republic of Zambia under PEPFAR	Activities within this Project include the implementation of Programs to improve	U2GPS000641	Eastern Provincial Health Office	N	Y	\$200,000

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CDC	Implementation of Programs to Improve the Management of Care for HIV/AIDS, Sexually Transmitted Infection and Tuberculosis in the Western Province of the Republic of Zambia under PEPFAR	Improve the Management of Care for HIV/AIDS STIs & TB in the Western Province of Zambia	U2G/PS000646	Western Provincial Health Office	N	Y	\$1,215,000
CDC	Implementation of Programs to Improve the Management of Care for HIV/AIDS, Sexually Transmitted Infection and Tuberculosis in the Western Province of the Republic of Zambia under PEPFAR	Improve the Management of Care for HIV/AIDS STIs & TB in the Western Province of Zambia	U2G/PS000646	Western Provincial Health Office	N	Y	\$250,000
CDC	Improving Overseas Detection of Influenza among Refugees and Preventing the Importation of Avian Influenza among U.S. Bound - Thailand	Avian Flu Surveillance Network in Displaced Populations on the Thai Burma Border	U50 C1000473	Mahidol University	N	Y	\$250,000
CDC	Improving Overseas Health assessment and management of US Bound refugees	Improving Overseas Health assessment and management of US Bound refugees	U51C1000418	International Organization for Migration	N	Y	\$250,000
CDC	In-Country Development of H5N1 Vaccine in Vietnam	In-Country development of H5N1 Vaccine in Vietnam	U01C1000347	Company for Biological Production in Vietnam	N	Y	\$975,000
CDC	Information Interchange and Technical Assistance for Human Immunodeficiency Virus (HIV) Prevention -- Community-Based HIV Prevention	Financial Assistance for Human Immunodeficiency Virus (HIV) Prevention - Community-Based HIV Prevention	5 U62 PS 300609	The US Conference of Mayors Research and Information Found	N	Y	\$1,130,688
CDC	Mental Health of Humanitarian Aid Workers Program	Mental Health of Humanitarian Aid Workers	U01EH000217	Antares Foundation	N	Y	\$150,000
CDC	National Healthy Homes Training Center and Network	Continue Operation & Expansion of National Healthy Homes Training Ctr & Network	U38 EH000173	National Center For Healthy Housing	N	Y	\$492,249

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CDC	Program to Improve Capacity of an Indigenous Statutory Institution to Enhance Monitoring and Evaluation of HIV/AIDS in the Republic of South Africa as Part of PEPFAR	U2G/PS000570	Human Sciences Research Council	N	Y	\$4,900,000
CDC	Rural HIV/AIDS Prevention Program	U62 PS000136	Indiana University Bloomington	N	Y	\$245,471
CDC	Sample Vital Registration with Verbal Autopsy in the Republic of Zambia under PEPFAR	U2G/PS000635	Central Statistical Office	N	Y	\$150,000
CDC	Strengthening and Expanding HIV Prevention Education Among Primary-School Pupils Through Life-Planning Skills Education in the Republic of Tanzania Under PEPFAR	U2G PS000650	Ministry of Education and Vocational	N	Y	\$300,000
CDC	Strengthening the Capacity to Manage national HIV Programs and Improvement of Care and Treatment in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	U2G/PS000658	National AIDS Council	N	Y	\$100,000
CDC	Strengthening the Capacity to Manage national HIV Programs and Improvement of Care and Treatment in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	U2G/PS000658	National AIDS Council	N	Y	\$100,000
CDC	Support to the Republic of Rwanda's National Reference Laboratory to Strengthen HIV/AIDS Prevention, Care and Treatment Under PEPFAR	U2G PS000642	National Reference Laboratory	N	Y	\$600,000

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CDC	Supporting the Provision of a Safe and Adequate Supply of Blood and Blood Products to District Level Hospitals in the Republic of Malawi under PEPFAR	Supporting the Provision of a Safe and Adequate Supply of Blood and Blood Products to District Level Hospitals in the Republic of Malawi under PEPFAR	U2G/PS000630	Malawi Blood Transfusion Services	N	Y	\$250,000
CDC	Supporting the Provision of a Safe and Adequate Supply of Blood and Blood Products to District Level Hospitals in the Republic of Malawi under PEPFAR	Supporting the Provision of a Safe and Adequate Supply of Blood and Blood Products to District Level Hospitals in the Republic of Malawi under PEPFAR	U2G/PS000630	Malawi Blood Transfusion Services	N	Y	\$200,000
CDC	The Regional Emerging Diseases Intervention Center-Improving Influenza Surveillance and Pandemic Preparedness for H5N1 Avian Influenza-In-Country Support	Improving Influenza Surveillance and Pandemic Preparedness for H5N1 Avian Influenza	E11CH000001	Regional Emerging Diseases Intervention	N	Y	\$550,000
CDC	Unintentional Injury And Violence Prevention And Control Initiative Related To The Who	Prevention and Control of Unintentional Injury and Violence	E11 CE001101	World Health Organization	N	Y	\$172,000
CDC							
CDC		HIV/AIDS Prevention, Care and Treatment in the Federal Republic of Nigeria	I U2G PS000651-01	UNIVERSITY OF MARYLAND BALTIMORE			\$5,900,000
CDC		Improving the Lives of People Living with Epilepsy thru Edu. Awareness, & Informal Strengthening Influenza Surveillance (WHO/EMRO)	I U58 DP000606-01	EPILEPSY FOUNDATION OF AMERICA			\$3,503,797
CDC			I U51 CI000422-01	WORLD HLTH ORG--E MEDITERRANEAN OFFICE			\$2,550,000
CDC		Proposal for a Cooperative Agreement with the US Centers for Disease Control, Surveillance & Response to Avian and Pandemic Influenza	I U51 CI000434-01	WORLD HEALTH ORGANIZATION-WEST PACIFIC			\$2,050,000
CDC			I U51 CI000462-01	DIRECTORATE GEN/DIS CTRL/ENV HEALTH			\$2,000,000
CDC		PEPFAR Assistance Program for the Ethiopian Uniformed Services	I U2G PS000623-01	UNIVERSITY OF CALIFORNIA SAN DIEGO			\$1,905,000
CDC		California STD/HIV Prevention Training Center	I R30 PS000256-01	CA ST DEPT OF HLTH SRVS--STD CNTRL BRNCH			\$1,550,087

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CDC		Surveillance and Response to Avian and Pandemic Influenza by Regional Offices...	1 U51 CI000449-01	WORLD HEALTH ORGANIZATION-AFRO			\$1,332,000
CDC		Denver Prevention Training Center	1 R30 PS000255-01	DENVER HEALTH AND HOSPITAL AUTHORITY			\$1,271,171
CDC		The Basia Lesedi (Youth are the Light) Project	1 U2G PS000599-01	FAMILY HEALTH INTERNATIONAL			\$1,212,385
CDC		Tobacco Countermarketing program using a media campaign targeted to under-served	1 H75 DP000610-01	AMERICAN LEGACY FOUNDATION			\$1,200,000
CDC		Surveillance and Response to Avian and Pandemic Influenza in Vietnam	1 U51 CI000452-01	VIETNAM MINISTRY OF HEALTH			\$1,150,000
CDC		Surveillance and Response to Avian /Pandemic Influenza	1 U51 CI000457-01	PROGRAM/APPROPRIATE/TEC HNOLGY/HLTH			\$986,000
CDC		Surveillance/Response to Avian Flu/Pandemic Influenza	1 U51 CI000458-01	MEXICO NATIONAL INSTITUTE OF PUBLIC HLTH			\$925,000
CDC		New York City's Continued Develop of a Local & Nat'l Envir Pub Hlt Tracking Net	1 U38 EH000189-01	NEW YORK CITY HEALTHMENTAL HYGIENE			\$902,500
CDC		New York State Nat'l Environmental Pub Hlth Tracking Prog- Network Implementation	1 U38 EH000184-01	NEW YORK STATE DEPT OF HEALTH			\$902,500
CDC		WISCONSIN EPHT NETWORK IMPLEMENTATION	1 U38 EH000192-01	WISCONSIN STATE DEPT OF HLTH/FAMILY SVC			\$902,500
CDC		NATIONAL EPHT PROGRAM - NETWORK IMPLEMENTATION	1 U38 EH000181-01	MASSACHUSETTS STATE DEPT OF PUB HEALTH			\$901,751
CDC		Nat'l Environmental Public Health Tracking Program- Network Implementation	1 U38 EH000186-01	PUBLIC HEALTH INSTITUTE FUND EMPREEND CIENTIFICOS E TECNOLOGICOS			\$900,589
CDC		Improvement of Surveillance Capabilities & Development of Brazilian Influenza Pan	1 U51 CI000465-01	MINISTRY OF HEALTH			\$900,000
CDC		Surveillance and Response to Avian and Pandemic Influenza	1 U51 CI000467-01	MAYO CLINIC COLL OF MEDICINE ROCHESTER			\$900,000
CDC		BioSense	1 U38 HK000014-01				\$898,101
CDC		Washington State Environmental Public Health Tracking Network	1 U38 EH000179-01	WASHINGTON STATE DEPARTMENT OF HEALTH			\$897,439

FY 2006 Non-Cooperative Grants

CDC		NEW MEXICO IMPLEMENTATION OF EPHT NETWORK THAT WILL BE PART OF NATL EPHT NETWORK	1 U38 EH000183-01	NEW MEXICO STATE DEPARTMENT OF HEALTH OREGON STATE DEPARTMENT OF HUMAN SRVS		\$866,691
CDC		Oregon EPHTN Implementation	1 U38 EH000175-01			\$865,584
CDC		National Environmental Public Health Tracking Program for Missouri Sexually Transmitted Diseases/Human Immunodeficiency Virus Prevent Training Ctr	1 U38 EH000188-01	MISSOURI STATE DEPT/ HEALTH & SENIOR SRV		\$861,139
CDC		STD/HIV Prevention Training Centers - Part II	1 R30 PS000250-01	UNIVERSITY OF ROCHESTER UNIVERSITY OF TEXAS SW MED CTR/DALLAS		\$851,836
CDC		Environmental & Occupational Health Program	1 R30 PS000252-01			\$851,835
CDC		Strengthening Avian Influenza Surveillance & Pandemic Influenza Preparedness Plan	1 U38 EH000185-01	MAINE STATE DEPT/HEALTH/HUMAN SRVS		\$850,596
CDC		Proposal for a Cooperative Agreement with the US Centers for Disease Control..... Support for the Plan of Preparation/Response against a Potential Influenza Pandem	1 U51 CD000451-01	WORLD HEALTH ORGANIZATION		\$832,000
CDC		NATIONAL ENVIRONMENTAL PUBLIC HEALTH TRACKING PROGRAM - NETWORK IMPLEMENTATION	1 U51 CD000433-01	WORLD HEALTH ORGANIZATION SO EAST ASIA		\$831,906
CDC		Maryland Environmental Public Health Tracking Network Implementation Development of Influenza Surveillance Networks Overseas	1 U51 CD000456-01	MINISTRY OF HEALTH		\$825,000
CDC		Florida EPHT Network Implementation Bringing Value Through BioSense A Performance-Based Approach	1 U38 EH000191-01	PENNSYLVANIA STATE DEPT OF HEALTH		\$821,500
CDC			1 U38 EH000194-01	MARYLAND STATE DEPT OF HLTH/MTL HYGIENE		\$781,715
CDC			1 U51 CD000394-01	ROYAL GOVERNMENT OF CAMBODIA		\$780,300
CDC			1 U38 EH000177-01	FLORIDA STATE DEPARTMENT OF HEALTH		\$757,402
CDC			1 U38 HK000013-01	JOHNS HOPKINS UNIVERSITY		\$739,817

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CDC	Implementation Strategies to Increase Arthritis/Specific Evidence Based Programs	1 U58 DP000607-01	ARTHRITIS FOUNDATION			\$736,000
CDC	NID of Health & Senior Services Plan for Network Implementation	1 U38 EH000196-01	NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS			\$732,121
CDC	A Community-level HIV Prevention Intervention for Young Black Men	1 UR6 PS000334-01	UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$718,016
CDC	Sustainable Development of the Connecticut Envir Public Health Tracking Network	1 U38 EH000193-01	CONNECTICUT STATE DEPT OF PUBLIC HEALTH			\$712,500
CDC	The Global Surveillance Network of ISTM and CDC	1 U50 CH000359-01	INTERNATIONAL SOCIETY OF TRAVEL MEDICINE			\$711,250
CDC	NATIONAL EPHT PROGRAM - NETWORK IMPLEMENTATION	1 U38 EH000182-01	UTAH STATE DEPARTMENT OF HEALTH			\$680,352
CDC	Environmental Public Health Tracking- Network Implementation Plan	1 U38 EH000174-01	NH STATE DEPT/HLTH STATISTICS/DATA MGMT			\$663,121
CDC	Strengthening Influenza Surveillance Networks in Morocco	1 U51 CH000469-01	MINISTRY OF HEALTH, MOROCCO			\$625,000
CDC	Addressing Asthma from a Public Health Perspective (Expanded)	1 U59 EH000212-01	NEW YORK STATE DEPT OF HEALTH			\$600,000
CDC	Developing a sustainable electronic reporting & monitoring system for HIV/AIDS	1 U7G PS000622-01	VOXIVA, INC.			\$600,000
CDC	Addressing Asthma from a Public Health Perspective (Expanded)	1 U59 EH000213-01	MICHIGAN STATE DEPT OF COMMUNITY HEALTH			\$580,190
CDC	Addressing Asthma from a Public Health Perspective (Expanded)	1 U59 EH000203-01	OREGON STATE DEPARTMENT OF HUMAN SRVS			\$566,681
CDC	Strengthening Applied Epidemiology Training Programs in Africa	1 U2R GH000001-01	AFRICAN FIELD EPIDEMIOLOGY NETWORK LTD			\$550,000
CDC	Early Detection Surveillance & Response for Highly Pathogenic Influenza A Viruses	1 U50 CH000472-01	UNIVERSITY OF MINNESOTA TWIN CITIES			\$500,000
CDC	Improving uptake of preventing mother-to-child transmission	1 U2G PS000600-01	KAGISO EDUCATIONAL TELEVISION			\$500,000

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CDC	BioSense Evaluation to Assess System Operations, Data Quality and Cost	1 U38 HK000009-01	RESEARCH TRIANGLE INSTITUTE		\$472,549
CDC	Expansion of HIV/AIDS Comprehensive Care & Treatment in Republic of Cote d'Ivoire	1 U2G PS000615-01	ACONDA		\$465,000
CDC	Strengthening Laboratory Capacity in Tanzania to Support Increased HIV/AIDS Ident	1 U2G PS000595-01	AFRICAN MEDICAL & RESEARCH FOUNDATION		\$463,366
CDC	Initiative to Integrate clinical laboratories into public health testing	1 U38 HM000018-01	MONTANA ST DEPT OF HLTH & ENVRNMTL SCIS		\$450,248
CDC	HIV Prev. Proj. for YMSM and Young Transgender Persons of Color	1 U22 PS000540-01	SEXUAL MINORITY YOUTH ASSISTANCE LEAGUE		\$450,000
CDC	PS06-618: HIV Prevention Program Targeting Young Transgender Persons of Color	1 U22 PS000509-01	BRONX AIDS SERVICES, INC.		\$450,000
CDC	NCourage Human Immunodeficiency Virus (HIV) Prevention Projects for Young Men of Color Who	1 U22 PS000511-01	AIDS TASK FORCE OF GREATER CLEVELAND NATIVE AMERICAN COMMUNITY HEALTH CENTER		\$449,975
CDC	HIV Prevention Projects for Young Men of Color MSM and Young Transgender	1 U22 PS000517-01	BIENESTAR HUMAN SERVICES, INC.		\$449,857
CDC	HIV Prev. Proj. for YMSM and Young Transgender Persons of Color	1 U22 PS000530-01	AIDS HEALTHCARE FOUNDATION		\$449,720
CDC	Strengthening and Expanding routine HIV counseling & testing & integrating preve	1 U2G PS000597-01	INTRAHEALTH INTRNATIONAL, INC.		\$445,238
CDC	CBA to Improve the Delivery and Effectiveness of HIV Prevention Interventions	1 U65 PS000388-01	UNIVERSITY OF TEXAS SW MED CTR/DALLAS		\$430,710
CDC	PS06-003, Opt-Out HIV Testing in Emergency Dept settings	1 U18 PS000314-01	DENVER HEALTH AND HOSPITAL AUTHORITY		\$427,835
CDC	Creating Risk Reduction Interventions for Black Boys (C.R.R.I.B.)	1 U22 PS000473-01	NATIONAL AIDS EDUC & SRVS FOR MINORITIES		\$418,470
CDC	PS06-003, Opt-Out HIV Testing Emergency Department Settings	1 U18 PS000321-01	ALAMEDA COUNTY MEDICAL CENTER		\$416,602

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CDC		HIV Prev. Proj. for YMSM and Young Transgender Persons of Color	1 U22 PS000534-01	SEXUAL MINORITY ALLIANCE OF ALAMEDA CNTY			\$409,500
CDC		PS06-618: HIV Prevention Program Targeting Young Transgender Persons of Color	1 U22 PS000502-01	NORTH JERSEY AIDS ALLIANCE, INC. (NJCAI)			\$406,532
CDC		BioSense Utility	1 U38 HK000015-01	EMORY UNIVERSITY			\$405,787
CDC		Creating STD/HIV Prevention Training Ctr in High-Risk Areas of Region II	1 R30 PS000248-01	PUBLIC HEALTH SOLUTIONS			\$399,536
CDC		HIV Prev. Proj. YMSM and Young Transgender Persons of Color	1 U22 PS000476-01	LA CLINICA DEL PUEBLO, INC.			\$397,260
CDC		STD/HIV Prev Training Ctr Part I to Provide STD and HIV Clinical and Lab Training	1 R30 PS000260-01	FLORIDA STATE DEPARTMENT OF HEALTH			\$392,036
CDC		Sexually Transmitted Diseases/Human Immunodeficiency Virus Prev Training Ctr....	1 R30 PS000253-01	UNIVERSITY OF ALABAMA AT BIRMINGHAM			\$392,036
CDC		Seattle STD/HIV Prevention Training Center	1 R30 PS000258-01	UNIVERSITY OF WASHINGTON			\$384,536
CDC		PS06-618: HIV Prevention Projects for Young Men of Color Who Have Sex With Young	1 U22 PS000541-01	AIDS PARTNERSHIP MICHIGAN, INC.			\$380,975
CDC		Category 2: Capacity Building Assistance for State Health Agencies	1 U58 DP000387-01	ASSN OF MATERNAL & CHILD HEALTH PROGRAMS			\$378,000
CDC		Surveillance & Response to Avian & Pandemic Influenza by Nat'l Hlth Auth outside	1 U51 CI000460-01	NATIONAL CENTER/DISEASE CTRL/MED STATS			\$375,000
CDC		Surveillance & Response to Avian and Pandemic Influenza by National Health Author	1 U51 CI000463-01	MINISTRY OF HEALTH AND FAMILY WELFARE			\$375,000
CDC		Surveillance/Response to Avian/Pandemic Influenza by the Sea Hygiene/Anti-Epidemi	1 U51 CI000461-01	ARMENIA MINISTRY OF HEALTH			\$375,000
CDC		National Tribal Tobacco Prevention Network (Asian Pacific)	1 U1A DP000546-01	ASSOCIATION/ASIAN PACIFIC CMY HLTG ORGS			\$374,927
CDC		HIV Prevention Regional Training Center-Region V	1 R30 PS000262-01	CINCINNATI HEALTH DEPARTMENT			\$374,536

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CDC	STD/HIV Prevention Training Center	I R30 PS000261-01	MASSACHUSETTS STATE DEPT OF PUB HEALTH		\$374,536
CDC	Sexually Transmitted Diseases/Human Immunodeficiency Virus Prevention Training Ctr	I R30 PS000259-01	JOHNS HOPKINS UNIVERSITY		\$374,535
CDC	St. Louis STD/HIV Prevention Training Center	I R30 PS000247-01	WASHINGTON UNIVERSITY		\$374,535
CDC	Human Immunodeficiency Virus (HIV) Prevention Projects for Young Men of Color Who	I U22 PS000494-01	TARZANA TREATMENT CENTERS, INC		\$373,229
CDC	PS06-618: HIV Prev Prgm Targeting Young MSM & Transgender Persons of Color	I U22 PS000522-01	ASIAN/PACIFIC ISLANDR COALTN ON HIV/AIDS COLLEGE OF HEALTH SCIS		\$360,000
CDC	Improving the Quality of HIV/AIDS Care in Zimbabwe under PEPFAR	I U2G PS000594-01	UNIV OF ZIMBABWE		\$350,000
CDC	Enhanced State Capacity to Address Child & Adolescent Health Thru Violence Prevention	I U82 CE001056-01	COLORADO STATE DEPT/PUB HLTH & ENVIRONMT		\$343,453
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000199-01	RHODE ISLAND STATE DEPT OF HEALTH		\$335,000
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000200-01	NEW MEXICO STATE DEPARTMENT OF HEALTH		\$335,000
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000201-01	MAINE STATE DEPT/HEALTH/HUMAN SRVS		\$335,000
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000202-01	IOWA STATE DEPT OF PUBLIC HEALTH		\$335,000
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000206-01	NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS		\$335,000
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000208-01	MISSISSIPPI STATE DEPARTMENT OF HEALTH		\$335,000
CDC	Addressing Asthma from a Public Health Perspective (Limited)	I U59 EH000214-01	OHIO STATE DEPARTMENT OF HEALTH		\$335,000
CDC	Addressing Asthma from a Public Health Perspective	I U59 EH000216-01	VERMONT STATE DEPT OF HEALTH		\$335,000
CDC	Puerto-Rico Asthma Project	I U59 EH000211-01	PUERTO RICO DEPARTMENT OF HEALTH		\$335,000

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CDC	PS06-618 HIV Prevention Projects for Young Men of Color and Young Transgender	1 U22 PS000469-01	FAMILY HEALTH CENTERS OF SAN DIEGO, INC.			\$332,524
CDC	Addressing Asthma from a Public Health Perspective (Limited)	1 U59 EH000198-01	PENNSYLVANIA STATE DEPT OF HEALTH			\$327,779
CDC	Strengthening national Surveillance System for A/Pandemic Influenza Threat	1 U51 CI000455-01	REPUBLIC OF TURKEY MINISTRY OF HEALTH			\$325,000
CDC	Support Surveillance and Response to Avian and Pandemic Influenza	1 U51 CI000468-01	MINISTRY OF HEALTH			\$325,000
CDC	Surveillance/Response to Avian /Pandemic Influenza By National Health Authorities	1 U51 CI000454-01	MINISTRY OF HEALTH KENYA			\$325,000
CDC	STD/HIV Prevention Training Center	1 R30 PS000246-01	NEW YORK STATE DEPT OF HEALTH			\$323,717
CDC	STD/HIV Prev Training Ctr. Part III, STD/HIV Partner Svcs & Prog Supp Train.....	1 R30 PS000249-01	COLORADO STATE DEPT/PUB HLTH & ENVIRONMT			\$323,716
CDC	Sexually Transmitted Disease/Human Immunodeficiency Virus Prev Training Ctr	1 R30 PS000251-01	TEXAS STATE DEPT OF HEALTH SERVICES			\$323,716
CDC	Human Immunodeficiency Virus (HIV) Prevention Projects for Young Men of Color Who	1 U22 PS000486-01	HOWARD BROWN HEALTH CENTER			\$322,000
CDC	Human Immunodeficiency Virus (HIV) Prevention Projects for Young Men of Color Who	1 U22 PS000506-01	MY BROTHERS KEEPER, INC.			\$322,000
CDC	AIDS Alliance Building the Capacity of Community-Based Organiz to Prev HIV	1 U58 DP000397-01	AIDS ALLIANCE FOR CHILDREN/YOUTH/FAMILIES			\$320,000
CDC	Adolescent HIV & STD Prev: Building the Cap of Loc Hlt Dept to Collaborate with...	1 U58 DP000462-01	NATL ASSN OF COUNTY/CITY HLTH OFFICIALS			\$320,000
CDC	Building the Capacity of Societal Instit Serv African Amerit & Latina Young Women	1 U58 DP000464-01	ADVOCATES FOR YOUTH			\$320,000
CDC	CBA for HIV Prevention with YMMSM	1 U58 DP000440-01	AMERICAN PSYCHOLOGICAL ASSOCIATION			\$320,000
CDC	Category 1: Preventing HIV Infections by Prov CBA to State & Local Edu Agencies:	1 U58 DP000416-01	ST DIRECTORS/HLTH/PHYS EDUC & REHAB			\$320,000

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CDC		Category 3B: Healthy Girls Initiative	1 U58 DP000396-01	GIRLS, INC.			\$320,000
CDC		Prevent Plus Project to Provi Enhanc Capacity Building Assist for HIV & STD Prev.	1 U58 DP000406-01	NATIONAL NETWORK FOR YOUTH			\$320,000
CDC		Natl Prog to Build the Capacity of Societal Insitit that Infla Youth Behavior.	1 U58 DP000447-01	NATIONAL ASSOCIATION OF STATE BDS OF EDU			\$319,999
CDC		Survive Outside	1 U58 DP000436-01	EDUCATION, TRAINING, & RESEARCH ASSOCS			\$319,992
CDC		No Excuse (Sin Biscar Excusas) Intervention to Reduce Latino Men's HIV Risks	1 UR6 PS000425-01	EDUCATION DEVELOPMENT CENTER, INC.			\$318,953
CDC		Human Immunodeficiency Virus (HIV) Prevention Projects for Young Men of Color Who	1 U22 PS000549-01	METROLINA AIDS PROJECT			\$318,493
CDC		PS06-618: HIV Prevention Program Targeting Young Transgender Persons of Color	1 U22 PS000527-01	PREVENTION POINT PHILADELPHIA			\$316,244
CDC		A Network Intervention for Reducing Sexual Risk for HIV with African American MSM	1 UR6 PS000355-01	JOHNS HOPKINS UNIVERSITY			\$308,890
CDC		Campus Health Advocates Mobilizing Preventing Strategies (CHAMPS) Network Consort	1 U58 DP000442-01	UNITED NEGRO COL FUND SPECIAL PROGRAMS			\$300,000
CDC		National Network Tobacco Control and Prevention (NAATEN)	1 U1A DP000551-01	HEALTH EDUCATION COUNCIL			\$300,000
CDC		National Network for Tobacco Control (Lesbian, Gay, Bisexual, & Transgender)	1 U1A DP000558-01	FENWAY COMMUNITY HEALTH CENTER			\$300,000
CDC		Tuberculosis/HIV Integration Activities in the Republic of Uganda Under the Pres National Tribal Tobacco Prevention Network	1 U2G PS000608-01	AIDS INFORMATION CENTRE- UGANDA			\$300,000
CDC		Culturally-Tailored HIV Risk Reduction for African-American MSM	1 U1A DP000556-01	NORTHWEST PORTLAND AREA INDIAN HLTH BD			\$299,946
CDC		Cooperative Agreement for Natl Prog to Build the Capacity of Societal Insitit that	1 UR6 PS000434-01	MEDICAL COLLEGE OF WISCONSIN			\$299,769
CDC			1 U58 DP000398-01	AMERICAN ASSN OF SCHOOL ADMINISTRATORS			\$299,673

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CDC	Reducing Sexual Risk in African American Men Who Have Sex With Men: Cooking Club	1 UR6 PS000437-01	NEW YORK BLOOD CENTER				\$298,327
CDC		1 US8 DP000449-01	AMERICAN LUNG ASSOCIATION				\$297,397
CDC	Asthma-Friendly Schools Initiative	1 UR6 PS000433-01	NOVA SOUTHEASTERN UNIVERSITY				\$296,277
CDC	Projecto SOL: A Risk Reduction Intervention for Hispanic MSM	1 R01 OH009064-01	UNIVERSITY OF COLORADO AT BOULDER				\$292,424
CDC	Microbiological Characterization and Mitigation of Bioaerosols in CAFOs	1 UR6 PS000364-01	CENTERFORCE, INC.				\$291,060
CDC	HIV Prevention Research with HIV+ Incarcerated Populations	1 UR6 PS000391-01	AIDS PROJECT HARTFORD, INC.				\$291,060
CDC	HIV Prevention with HIV+ Incarcerated Men	1 UR6 PS000366-01	TEMPLE UNIVERSITY				\$291,060
CDC	Enhancing State Capacity to Address Child & Adolescent Health Trauma Violence Prevention	1 UR2 CE001055-01	VIRGINIA STATE DEPT OF HEALTH				\$290,615
CDC	National Network for Tobacco Control and Prevention	1 U1A DP000548-01	NATL LATINO COUNCIL ON ALCOHOL/TOBACCO				\$290,375
CDC	National Network for Tobacco Control and Prevention (Low SES)	1 U1A DP000559-01	HEALTH EDUCATION COUNCIL				\$288,451
CDC	HIV Prevention Projects for Young Men of Color MSM and Young Transgender	1 U22 PS000515-01	GAY MEN'S HEALTH CRISIS, INC.				\$284,460
CDC	PS06-618: HIV Prevention Program Targeting Young Transgender Persons of Color	1 U22 PS000485-01	LESTER AND ROSALIE ANXTER CENTER				\$284,416
CDC	HIV PREVENTION PROJECT	1 U22 PS000510-01	UNION POSITIVA, INC.				\$282,813
CDC	HIV Prev. Proj. for YMSM and Young Transgender Persons of Color	1 U22 PS000523-01	ST HOPE FOUNDATION				\$280,251
CDC	Category 7C: Prev Chronic Dis by Provi CBA to ST & Loc Edu Agencies Prev Initia.	1 US8 DP000390-01	NATIONAL SCHOOL BOARDS ASSOCIATION				\$275,000
CDC	Increasing the Quality and Quantity of Youth Physical Activity Programs	1 US8 DP000420-01	AMERICAN ALLIANCE FOR HLTH PHY ED REC DA				\$275,000

FY 2007 Non-Competitive Grants

CDC	Promoting Coordinated Schol Hlth Prog: Sup Leadership & Gov for Coordinated Schol.	1 U58 DP000419-01	NATIONAL SCHOOL BOARDS ASSOCIATION		\$274,999
CDC	Natl Prog to Build The Capacity of Societal Instit that Influence Youth Behavior	1 U58 DP000446-01	NATIONAL ASSOCIATION OF STATE BDS OF EDU		\$274,981
CDC	Category 8: Promoting Coordinated Sch Hlth Prog by Prov CBA to St & Loc Edu Agen	1 U58 DP000434-01	ST DIRECTORS/HLTH/PHYS EDUC & REHAB		\$274,895
CDC	Formative Internet-based HIV Prevention Research for Persons Living with HIV	1 UR6 PS000341-01	UNIVERSITY OF MINNESOTA TWIN CITIES		\$273,556
CDC	Testing Interventions to Human-Generated Occupational Airborne Infections	1 R01 OH009050-01	BRIGHAM AND WOMEN'S HOSPITAL		\$263,700
CDC	HIV Prevention Projects for Young MSM and Transgender Persons of Color	1 U22 PS000479-01	COAL INC.		\$263,434
CDC	Culture and prevention: Tailored Intervention for African American MSM	1 UR6 PS000429-01	HOWARD BROWN HEALTH CENTER		\$256,851
CDC	Surveillance and Response to Avian and Pandemic Influenza	1 U51 CI000466-01	MINISTRY OF HEALTH		\$250,000
CDC	Improving the Overseas Detection & Prev the Importation of Communicable Infect...	1 U50 CI000470-01	INTERNATIONAL RESCUE COMMITTEE		\$250,000
CDC	Capacity Building Assist (CBA) for ST Health Agencies (SHAs) to Strengthen Agen.	1 U58 DP000410-01	NATIONAL COALITION OF STD DIRECTORS		\$250,000
CDC	SIECUS' School Health Project	1 U58 DP000423-01	SIECUS		\$250,000
CDC	Using Respondent-Driven Sampling to Reach Black and White Bisexually-Active Men	1 UR6 PS000324-01	PHILADELPHIA HEALTH MANAGEMENT CORP		\$250,000
CDC	HIV Prevention Program for National Medical Associations	1 U22 PS000553-01	NATIONAL MEDICAL ASSOCIATION		\$250,000
CDC	TCE Zambia- Total control of the Epidemic. A house-to-house approach to strenght	1 U2G PS000588-01	DEVELOPMENT AID FROM PEOPLE TO PEOPLE		\$250,000
CDC	SCIM Project: HIV Prevention with National Medical Associations	1 U22 PS000551-01	SOCIETY OF GENERAL INTERNAL MEDICINE		\$249,952

FY 2007 Non-Competitive Grants

CDC		Strategies for Identifying At-Risk African American (MSM)	1 UR6 PS000329-01	BALTIMORE CITY HEALTH DEPARTMENT			\$247,516
CDC		Providing Professional Develop for Others DASH Funded NGO Partners Category 10.	1 U58 DF000438-01	EDUCATION, TRAINING, & RESEARCH ASSOCS			\$244,997
CDC		The Infectious Diseases Society of America Emerging Infections Network (EIN)	1 U50 CI000358-01	INFECTIOUS DISEASES SOCIETY OF AMERICA			\$243,335
CDC		PACPI Perinatal HIV Enhanced Case Management: Expansion and Evaluation	1 U62 PS000291-01	PEDIATRIC AIDS CHICAGO PREVENTION INITIA			\$242,595
CDC		PS06-002 Rap Test Algorithm in Non-Trad Test Sites to Improve Linkage to Care	1 U18 PS000292-01	SAN FRANCISCO DEPT OF PUBLIC HEALTH			\$242,573
CDC		PS06-002 Rap Test Algorithm in Non-Trad Test Sites to Improve Linkage to Care	1 U18 PS000295-01	LOS ANGELES COUNTY HEALTH SERVICES DEPT			\$242,363
CDC		Cost and Effectiveness Evaluation of the Circle of Care's HIV Perinatal Case Mgmt	1 U62 PS000286-01	FAMILY PLANNING COUNCIL, INC.			\$240,492
CDC		Project Access A Community Collaboration to Increase HIV Serostatus Awareness for At Risk AA MSM	1 UR6 PS000368-01	HARLEM UNITED COMMUNITY AIDS CENTER, INC			\$237,846
CDC		PS06-618 CATEGORY A AND B HIV PREVENTION PROJECTS FOR YMCMSM AND YTG IN HOUSTON MS	1 UR6 PS000340-01	AIDS RESEARCH CONSORTIUM OF ATLANTA, INC			\$237,548
CDC		PS06-618 HIV PREVENTION PROJECTS FOR YMCMSM & YTG	1 U22 PS000531-01	HOUSTON AREA COMMUNITY SERVICES, INC.			\$237,073
CDC		HIV Prevention Projects for Young Men of Color MSM and Young Transgender	1 U22 PS000544-01	TAMPA-HILLSBOROUGH ACTION PLAN, INC.			\$235,714
CDC		Experimental and Theoretical Study of Early Detection and Isolation Influenza	1 U22 PS000513-01	BROTHERHOOD, INC.			\$233,314
CDC		Evaluation of Relative Effect of Four Pub Hlth Strat for Prev HIV Test to High-Ri	1 R01 OH0009037-01	WEST VIRGINIA UNIVERSITY			\$230,738
CDC			1 U62 PS000199-01	HARLEM UNITED COMMUNITY AIDS CENTER, INC			\$229,247

FY 2007 Non-Competitive Grants

CDC	CBA to Improve the Delivery and Effectiveness of HIV Prevention Interventions	1 U65 PS000386-01	NATIONAL ASSOCIATION OF PEOPLE WITH AIDS			\$228,271
CDC	Expansion of Community-Led, Age-Appropriate HIV/AIDS Prev & Care in the Republic	1 U2G PS000633-01	ALLIANCE NATIONALE CONTRE LE SIDA			\$225,000
CDC	Strategies for Identifying African American MSM Unaware of Their HIV Status	1 UR6 PS000330-01	ABT ASSOCIATES, INC.			\$224,345
CDC	Motivating Changes in Condom, Methamphetamine Use During MSM Sexual Encounters	1 UR6 PS000310-01	RESEARCH TRIANGLE INSTITUTE			\$218,295
CDC	Novel HIV Prevention for African American, Methamphetamine-Involved Male Couples	1 UR6 PS000300-01	COLUMBIA UNIV NEW YORK MORNINGSID			\$218,295
CDC	Reducing Sexual HIV Risk among Methamphetamine-Using MSM in San Diego, CA	1 UR6 PS000306-01	UNIVERSITY OF CALIFORNIA SAN DIEGO			\$218,295
CDC	Evaluation of the Relative Effectiveness of Four Public Health Strategies for Pro	1 U62 PS000186-01	FAMILIES UNDER URBAN AND SOCIAL ATTACK			\$217,089
CDC	Initiative to Integrate Clinical Laboratories into Public Health Testing	1 U38 HM000012-01	UNIVERSITY OF WISCONSIN MADISON			\$216,164
CDC	PS06-607: Enhanced Perinatal HIV Surveillance	1 U62 PS000233-01	NEW YORK CITY HEALTH/MENTAL HYGIENE			\$215,108
CDC	Evaluation of the Relative Effectiveness of Four Public Health Strategies for Pro	1 U62 PS000206-01	SISTERS TOGETHER AND REACHING, INC.			\$212,748
CDC	PS06-618: HIV Prevention Program Targeting Young Transgender Persons of Color	1 U22 PS000475-01	AID ATLANTA, INC.			\$210,308
CDC	Demonstrating the benefits of a mul-state strategy to improve clinical integration	1 U38 HM000014-01	FOUNDATION FOR HEALTH CARE QUALITY			\$206,178
CDC	Evaluation of the Relative Effectiveness of Four Public Health Strategies for Pro	1 U62 PS000182-01	WRIGHT STATE UNIVERSITY			\$203,907
CDC	Enhancing Child Maltreatment Prev Initiatives Through Parents Anonymous Inc.	1 U81 CE001039-01	PARENTS ANONYMOUS, INC.			\$201,250

FY 2007 Non-Competitive Grants

CDC		Implementation of a National Plan Focused on the Prev of Child Abuse & Neglect...	1 U81 CE001040-01	PREVENT CHILD ABUSE AMERICA			\$201,250
CDC		Implementing & Evaluating a National Plan to Strengthen Families & Prev Child...	1 U81 CE001041-01	NAT ALLIANCE OF CHILD ABUSE PREV			\$201,250
CDC		Monitoring & Evaluation of the US President's Malaria Initiative in Mainland Tanz.	1 U61 CE000423-01	TANZANIA MINISTRY OF HEALTH/SOCIAL WLFRE			\$200,120
CDC		Influenza Preparedness in the Americas Region	1 U51 CE000450-01	PAN AMERICAN HEALTH ORGANIZATION			\$200,013
CDC		Surveillance and Response to Avian and Pandemic Influenza	1 U51 CE000464-01	UNIVERSITY OF KINSHASA			\$200,000
CDC		Category 8B: School Health Coordinators' Role Delineation Project	1 U58 DP000426-01	AMERICAN SCHOOL HEALTH ASSOCIATION			\$200,000
CDC		Assessment/development of an antimicrobial susceptibility testing program/Nebras	1 U38 HM000010-01	UNIVERSITY OF NEBRASKA MEDICAL CENTER			\$200,000
CDC		Project START Intervention Translation	1 U65 PS0000231-01	CENTERFORCE, INC.			\$200,000
CDC		Translation of HIV	1 U65 PS000242-01	UNIVERSITY OF PENNSYLVANIA			\$200,000
CDC		Translating Proven Interventions for Underserved and Emergent High-Risk Populatio	1 U65 PS000239-01	COLUMBIA UNIVERSITY			\$200,000
CDC		PS06-018: HIV Prevention Program Targeting Young Transgender Persons of Color	1 U22 PS000500-01	CHILDRENS HOSPITAL LOS ANGELES			\$198,677
CDC		PS06-649: Packaging of Proven HIV Behavioral Interventions	1 H62 PS000573-01	UNIVERSITY OF TEXAS SW MED CTR/DALLAS			\$197,585
CDC		PS06-649: Packaging of Proven HIV Behavioral Interventions	1 H62 PS000580-01	JOHNS HOPKINS UNIVERSITY			\$195,747
CDC		Keep It Up: Peak Performance for Life HIV Intervention for African American Males	1 UR6 PS000399-01	EDUCATION DEVELOPMENT CENTER, INC.			\$195,548
CDC		Packaging of Proven HIV Behavioral Interventions for Use with Underserved and Emte	1 H62 PS000581-01	UNIVERSITY OF MICHIGAN AT ANN ARBOR			\$195,439
CDC		Monitoring and Evaluation of the US President's Malaria Initiative in Zanzibar	1 U61 CE000424-01	TANZANIA MINISTRY OF HEALTH/SOCIAL WLFRE			\$194,895

FY 2007 Non-Competitive Grants

CDC		Coordinating Center for the National Academic Centers of Excellence on Youth Violence	1 U38 CE001061-01	UNIVERSITY OF HAWAII AT MANOA			\$194,600
CDC		Development /Evaluation of Group HIV Intervention for Gender Stigmatized Persons	1 UR6 PS000422-01	HUNTER COLLEGE			\$194,576
CDC		Life Skills Intervention: Safety and Coping Among Transgender Youth Adults	1 UR6 PS000396-01	HOWARD BROWN HEALTH CENTER			\$194,272
CDC		A Novel Online Intervention to Reduce Sexual Risk Among Men Who Meet Men Online	1 UR6 PS000415-01	PUBLIC HEALTH SOLUTIONS			\$193,307
CDC		Packaging of Proven HIV Behavioral Interventions for Use with Underserved and Ene	1 H62 PS000575-01	CHILDREN'S HOSPITAL LOS ANGELES			\$190,775
CDC		Building Capacity for Effective Coordination & Support for School Health Programs	1 U58 DP000452-01	WAIT TRAINING			\$185,840
CDC		Building Partnerships for Youth: Capacity Building to Promote Youth Development	1 U58 DP000456-01	NATIONAL 4-H COUNCIL			\$185,840
CDC		CBA for Societal Institutions Priority 5B: Connecting Parenting Adults and Youth	1 U58 DP000441-01	INSTITUTE FOR YOUTH DEVELOPMENT			\$185,840
CDC		School Mental Health (SMH-CBP) - Category 9	1 U58 DP000409-01	MEDICAL INSTITUTE FOR SEXUAL HEALTH			\$185,840
CDC		Provision of Quality Assurance for HIV	1 U2G PS000586-01	NATL ASSEMBLY ON SCHOOL-BASED HLTH CARE			\$175,000
CDC		BETWEEN BROTHERS PROGRAM	1 U22 PS000529-01	UGANDA VIRUS RESEARCH INSTITUTE			\$170,000
CDC		Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000275-01	SOUTH CAROLINA HIV/AIDS COUNCIL			\$164,598
CDC		National Tuberculosis Controllers Association (NTCA)	1 U52 PS000394-01	HOUSTON DEPARTMENT/HEALTH/HUMAN SRVS			\$146,663
CDC		Canvassing Households In Alaska for Working Smoke Alarms, Installation of Smoke	1 H28 CE000866-01	NATIONAL TUBERCULOSIS CONTROLLERS ASSN			\$142,500
				ALASKA STATE DEPARTMENT OF HLTH-SOC SVCS			\$141,087

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CDC	Oklahoma Residential Fire Injury Prevention Program	1 H28 CE000857-01	OKLAHOMA STATE DEPARTMENT OF HEALTH			\$141,065
CDC	Prevention of Fire-Related Injuries	1 H28 CE000855-01	MASSACHUSETTS STATE DEPT OF PUB HEALTH			\$140,997
CDC	Reducing Methamphetamine Use and HIV Sex-risk Behaviors in Out-of-Treatment MSM	1 U66 PS000312-01	VAN NESS RECOVERY HOUSE			\$140,759
CDC	Programs for the Prevention of Fire-Related Injuries	1 H28 CE000850-01	SOUTH CAROLINA STATE DEPT OF HLTH/ENV			\$140,223
CDC	Smoke Alarm Installation Program	1 H28 CE000837-01	CHILDREN'S HOSPITAL OF MICHIGAN			\$140,137
CDC	Kansas Fire Injury Prevention Program	1 H28 CE000865-01	KANSAS STATE DEPT OF HLTH AND ENVIRONMNT			\$140,113
CDC	Increasing Immunization Practices Among Obstetrician-Gynecologists	1 U66 IP000118-01	AMERICAN COLLEGE OF OB AND GYN			\$140,000
CDC	Inform, Implement, Immunize: ACP's Adult Immunization Outreach Program	1 U66 IP000116-01	AMERICAN COLLEGE OF PHYSICIANS			\$140,000
CDC	Pharmacists Connecting, Communicating & Collaborating for Improved Community Hlth	1 U66 IP000114-01	AMERICAN PHARMACEUTICAL ASSOCIATION			\$139,772
CDC	Coordinate/Oversee Local Community Smoke Alarm Installation and Fire Safety Educa	1 H28 CE000851-01	CABINET FOR HEALTH AND FAMILY SERVICES			\$139,699
CDC	Coordinate/Oversee Local Community Smoke Alarm Installation and Fire Safety Educa	7 H28 CE000851-02	UNIVERSITY OF KENTUCKY			\$139,699
CDC	Using Immunization Provider Partnerships to Increase Immunizations	1 U66 IP000113-01	INTERAMERICAN COLL/PHYSICIANS & SURGEONS			\$139,479
CDC	Using Private Partnerships to Increase Immunization Rates	1 U66 IP000119-01	AMERICAN ACADEMY OF FAMILY PHYSICIANS			\$139,452
CDC	Program to Reduce Fire Incidence Rates, Morbidity and Mortality	1 H28 CE000864-01	MARYLAND STATE DEPT OF HLTH/MTL HYGIENE			\$139,207
CDC	'Get Alarmed, North Carolina!' A Smoke Alarm Installation Project	1 H28 CE000847-01	NC STATE DEPT/HLTH & HUMAN SERVICES			\$139,139
CDC	Raising Citizens' Fire Prevention IQ	1 H28 CE000840-01	CITY OF DALLAS			\$139,047
CDC	Reduce Fire Deaths by Working with Fire Dept to Install Smoke Alarms in High Ris	1 H28 CE000846-01	GEORGIA DIVISION OF PUBLIC HEALTH			\$138,996

FY 2007 Non-Competitive Grants

CDC		Get Alarmed, Virginia!	1 H28 CE000844-01	VIRGINIA STATE DEPT OF HEALTH		\$138,811
CDC		Alabama Smoke Alarm Initiative (ASAI)	1 H28 CE000830-01	ALABAMA STATE DEPT OF PUBLIC HEALTH		\$138,608
CDC		PRESIDENTS MALARIA INITIATIVE	1 U61 CI000425-01	THE REPUBLIC OF UGANDA		\$138,500
CDC		Safe Asleep Program- Fire Prevention and Education	1 H28 CE000860-01	CITY OF BRIDGEPORT		\$132,572
CDC		Surveillance and Response to Avian And Pandemic Influenza	1 U51 CI000459-01	MINISTRY OF PUBLIC HEALTH		\$125,000
CDC		PS06-609, Outcome Monitoring of Healthy Relationship	1 U65 PS000458-01	JWCH INSTITUTE, INC.		\$125,000
CDC		PS06-610, Outcome Monitoring of VOICES/VOCES Intervention	1 U65 PS000464-01	OUR COMMON WELFARE, INC		\$124,994
CDC		Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000271-01	CENTER FOR COMMUNITY HEALTH		\$123,083
CDC		Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000278-01	NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS		\$122,666
CDC		PS06-610, Outcome Monitoring of VOICES / VOCES	1 U65 PS000463-01	FAM UNDER URBAN & SOCIAL ATTACK, IN		\$121,393
CDC		Outcome Monitoring of VOICES/VOCES	1 U65 PS000462-01	SOUTH CAROLINA HIV/AIDS COUNCIL		\$118,589
CDC		Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000276-01	LOUISIANA STATE DEPT OF HLTH & HOSPITALS		\$115,134
CDC		HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000273-01	CHICAGO DEPARTMENT OF PUBLIC HEALTH		\$111,561
CDC		Program to promote pediatric Environmental health Internationally	1 U61 TS000064-01	ASSOCIATION/OCCUPATIONAL & ENVIR CLINICS		\$110,090
CDC		PS06-609, Outcome Monitoring of Healthy Relationships	1 U65 PS000465-01	JEFFERSON COMPREHENSIVE CARE SYSTEM		\$107,144
CDC		PS06-609, Outcome Monitoring of Healthy Relationship	1 U65 PS000453-01	CASCADE AIDS PROJECT, INC		\$104,047
CDC		PS06-609, Outcome Monitoring of Healthy Relationship	1 U65 PS000456-01	BASIC NWEL, INC.		\$103,501
CDC		Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000274-01	MARYLAND STATE DEPT OF HLTH/MTL HYGIENE		\$101,764
CDC		Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000272-01	CITY OF PHILADELPHIA PUBLIC HEALTH DEPT		\$101,060

FY 2007 Non-Competitive Grants

CDC	PS06-609, Outcome Monitoring of Healthy Relationship	1 U65 PS000451-01	CENTERFORCE, INC.			\$100,000
CDC	PS06-609, Outcome Monitoring of Healthy Relationship	1 U65 PS000459-01	BEAT-AIDS, INC.			\$100,000
CDC	PS06-609, Outcome Monitoring of the Healthy Relationship Intervention	1 U65 PS000457-01	BRONX AIDS SERVICES, INC.			\$100,000
CDC	PS06-610, Outcome Monitoring of VOICES/VOICES	1 U65 PS000461-01	SOUTH TEXAS CNCL/ALCOHOL AND DRUG ABUSE			\$100,000
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000277-01	SOUTH CAROLINA STATE DEPT OF HLTH/ENV			\$99,260
CDC	Evaluating Integration of HIV/AIDS Surveillance Data with a Geographic Information Sys	1 U62 PS000559-01	VIRGINIA STATE DEPT OF HEALTH			\$97,480
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000779-01	TEXAS STATE DEPT OF HEALTH SERVICES			\$92,849
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000266-01	GEORGIA DIVISION OF PUBLIC HEALTH			\$82,432
CDC	Evaluating Integration of HIV/AIDS Surveillance with a Geographic Information Sys	1 U62 PS000554-01	COLORADO STATE DEPT/PUB HLTH & ENVIRONMT			\$80,000
CDC	Meeting Neighbors and Saving Lives	1 H28 CE000832-01	CITY OF ST. LOUIS			\$79,382
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000265-01	PUERTO RICO HEALTH DEPARTMENT			\$74,001
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000269-01	LOS ANGELES COUNTY HEALTH SERVICES DEPT			\$66,631
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000280-01	CONNECTICUT STATE DEPT OF PUBLIC HEALTH			\$66,174
CDC	Classifier Development for Literature in Public Health	1 E11 GD000004-01	GEORGIA INSTITUTE OF TECHNOLOGY			\$64,875
CDC	Evaluating Integration of HIV/AIDS Surveillance Data with a Geographic Information Sys	1 U62 PS000569-01	WASHINGTON STATE DEPARTMENT OF HEALTH			\$59,773
CDC	Enhanced HIV/AIDS Surveillance for Perinatal Prevention	1 U62 PS000267-01	DELAWARE DIVISION OF PUBLIC HEALTH			\$52,883
CDC	SURVEILLANCE AND RESPONSE TO AVIAN AND PANDEMIC INFLUENZA	1 U51 C1000453-01	MINISTRY OF PUBLIC HEALTH			\$0
CDC	California STD/HIV Prevention Training Center	3 R30 PS0000256-01S1	CA ST DEPT OF HLTH SRVS--STD CNTRL BRNCH			\$0

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CDC			3 R30 PS000255-01SI	DENVER HEALTH AND HOSPITAL AUTHORITY				\$0
CDC		Denver Prevention Training Center STD/HIV Prevention Training Centers - Part II	3 R30 PS000252-01SI	UNIVERSITY OF TEXAS SW MED CTR/DALLAS				\$0
CDC		Sexually Transmitted Diseases/Human Immunodeficiency Virus Prevent Training Ctr	3 R30 PS000250-01SI	UNIVERSITY OF ROCHESTER				\$0
CDC Total =								\$161,341,338

FY 2007 Non-Competitive Grants

Centers for Medicare and Medicaid Services (CMS)						
CMS	NA	Cost Effective and Scalable Strategies for Enrolling Medicare Beneficiaries in Medicare	1R0CMS300065	The National Council on Aging	Y	N
						\$156,200
CMS Total =						\$156,200

FY 2007 Non-Competitive Grants

Food and Drug Administration (FDA)						
FDA	Food and Drug Administration_Research	National Center for Food Safety and Technology	SU01FD000431	ILLINOIS INSTITUTE OF TECHNOLOGY	N	Y
FDA	Food and Drug Administration_Research	Botanical Dietary Supplements: Science-Base for Authentication and Analysis	2U01FD002071	UNIVERSITY OF MISSISSIPPI	N	Y
FDA	Food and Drug Administration_Research	Cooperative Agreement to Support the Joint Institute for Food Safety and Applied Nutrition	SU01FDU001418	UNIVERSITY OF MARYLAND, COLLEGE PARK	N	Y
FDA	Food and Drug Administration_Research	Collaborative Cardiovascular Drug Safety	1U01FD003379	Critical Path Institute	N	Y
FDA	Food and Drug Administration_Research	National Center for Food Safety and Technology	SU01FD000431	ILLINOIS INSTITUTE OF TECHNOLOGY	N	Y
FDA	Food and Drug Administration_Research	Arizona Food Safety & Security Monitoring Project	SU18 FD003139	AZ ST DEPARTMENT OF HEALTH SERVICES	N	Y
FDA	Food and Drug Administration_Research	Florida Food Safety & Security Monitor of FERN Samples	SU18 FD003146	FL ST DEPARTMENT OF AGRICULTURE & CONS SER	N	Y
FDA	Food and Drug Administration_Research	Minnesota Food Safety & Security Monitoring Project	SU18 FD003150	MIN DEPT OF AGRIC.	N	Y
FDA	Food and Drug Administration_Research	Assuring Radiation Protection	SU01FD000005	CONFERENCE OF RADIATION PROGRAM DIRECTORS, INC	N	Y
FDA	Food and Drug Administration_Research	Use of LC/MS, GC/MS and ICP/MS Analysis for the Screening & Identification of Toxic Substances in Food	SU18 FD003177	REGENTS OF UNIVERSITY OF CALIFORNIA	N	Y
FDA	Food and Drug Administration_Research	Iowa Food Safety in the Heartland	SU18 FD003170	UNIVERSITY OF IOWA	N	Y
FDA	Food and Drug Administration_Research	New Hampshire Food Safety (FERN)	SU18 FD003164	NH ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y
FDA	Food and Drug Administration_Research	Michigan Ruminant Feed Ban Support Project	SU18 FD003217	MI ST DEPARTMENT OF AGRICULTURE	N	Y
FDA	Food and Drug Administration_Research	Radiological Testing of Food Samples	1U18FD003388	WA ST DEPARTMENT OF HEALTH	N	Y
FDA	Food and Drug Administration_Research	Maryland Fern Safety and Security Monitoring Capacity Program	1U18FD003389	MARYLAND STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE	N	Y

FY 2007 Non-Competitive Grants

FDA	Food and Drug Administration_Research	Florida Ruminant Feed Ban Enhancement Project	5U18FD003225	FL ST DEPARTMENT OF AGRICULTURE & CONS SER	N	Y	\$239,888
FDA	Food and Drug Administration_Research	Illinois Ruminant Feed Ban Support Project	5U18 FD003222	IL DEPT OF AGRICULTURE	N	Y	\$233,528
FDA	Food and Drug Administration_Research	Wisconsin Expansion of DATCP's BSE Surveillance & Compliance Program	5U18 FD003211	WISCONSIN DEPARTMENT OF AGRICULTURE	N	Y	\$218,207
FDA	Food and Drug Administration_Research	Kansas BSE Inspection Program	5U18FD003223	KANSAS DEPT. OF AGRICULTURE	N	Y	\$133,147
FDA	Food and Drug Administration_Research	FERN Food Safety Activities at CAES	5U18 FD003157	CONNECTICUT AGRICULTURE EXPERIMENT STATION	N	Y	\$124,557
FDA	Food and Drug Administration_Research	Improving the Safety of Fresh Fruits & Vegetables - WERC Design Contest	5U01FD001941	NEW MEXICO STATE UNIVERSITY	N	Y	\$103,570
FDA	Food and Drug Administration_Research	Proyecto Informar FDA Hispanic Outreach Initiative	5U01FD002260	NATIONAL ALLIANCE FOR HISPANIC HEALTH (THE)	N	Y	\$41,720
FDA	Food and Drug Administration_Research	2006 Annual Educational Conference	1R13FD003324	ASSOCIATION OF FOOD & DRUG OFFICIALS			\$25,000
FDA	Food and Drug Administration_Research	Conference for Food Protection	1R13FD003325	Conference for Food Protection			\$25,000
FDA	Food and Drug Administration_Research	NEHA's 70th Annual Educational Conference	1R13FD003380	NATIONAL ENVIRONMENTAL HEALTH ASSOCIATION			\$25,000
FDA	Food and Drug Administration_Research	National Egg Regulatory Officials	1R13FD003326	NATL EGG REGULATORY OFFICIALS			\$25,000
FDA	Food and Drug Administration_Research	Americas Health Responders on Public Health Frontlines	1R13FD003376	PHS COMMISSIONED OFFICERS FOUNDATION			\$25,000
FDA	Food and Drug Administration_Research	Virgin Island Health Fraud Task Force Campaign	5R18FD002649	GOVERNOR JUAN F LLUIS HOSPITAL FOUNDATION	N	Y	\$15,000
FDA	Food and Drug Administration_Research	Tennessee health Fraud Task Force	1R18FD003387	TN Office of Inspector General	N	Y	\$15,000
FDA	Food and Drug Administration_Research	California Food Safety and Security Agency Team Conference	5R13FD002640	CA DEPT OF HEALTH SERVICES	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Food Safety Task Force Conference Grant	5R13FD002633	CO ST DEPT PUBLIC HLTH&ENVIRONMENT	N	Y	\$8,750
FDA	Food and Drug Administration_Research	District of Columbia Food Safety Task Force	5R13FD002637	DC DEPARTMENT OF HUMAN SERVICES	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Delaware Food Safety	1R13FD003345	DELAWARE HEALTH & SOCIAL SERVICES	N	Y	\$8,750

FY 2006 Non-Competitive Grants

FDA	Food and Drug Administration_Research	Iowa Food Safety Task Force Conference	SR13FD002637	IA ST DEPARTMENT OF INSPECTION & APPEALS	N	Y	\$8,750
FDA	Food and Drug Administration_Research	State Food Safety Task Force Meetings	SR13FD002630	MN DEPT OF AGRIC.	N	Y	\$8,750
FDA	Food and Drug Administration_Research	North Carolina Division of Public Health	SR13FD002639	NC ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Nebraska Food Safety Task Force Conference	SR13FD002632	NE ST DEPARTMENT OF AGRICULTURE	N	Y	\$8,750
FDA	Food and Drug Administration_Research	New Hampshire State Food Safety Task Force Meetings	SR13FD002629	NH ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Nevada Food Safety Task Force	SR13FD002638	NV ST DAIRY COMMISSION	N	Y	\$8,750
FDA	Food and Drug Administration_Research	New York Food Safety Task Force Meeting	SR13FD002627	NY ST DEPARTMENT OF AGRICULTURE & MARKETS	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Rhode Island State Food Safety Task Force	SR13FD002636	RI ST DEPARTMENT OF HEALTH	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Food Safety Task Force Conference Grant	SR13FD002622	STATE OF MISSOURI HEALTH AND SENIOR SERVICES	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Virginia Food Safety Task Force Meetings	SR13FD002641	VA DEPT OF AGRICULTURE & CONSUMER SVCS	N	Y	\$8,750
FDA	Food and Drug Administration_Research	Washington State Dept of Agriculture	IR13FD003344	WA ST DEPARTMENT OF AGRICULTURE	N	Y	\$8,750
FDA	Food and Drug Administration_Research	State Food Safety and Food Security Task Force Meetings Conference Grant Program	IR13FD003185	AK ST DEPT OF ENVIRONMENTAL CONSERVATION	N	Y	\$7,000
FDA	Food Safety and Security Monitoring Project	Virginia Food Safety & Security Monitoring Project	5U18 FD003148	VA ST DEPT OF GENERAL SERVICES	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	Shellfish Safety Assistance Project	FD-U-000891	INTERSTATE SHELLFISH SANITATION CONFERENCE	N	Y	\$320,500
FDA	Food Safety and Security Monitoring Project	International Programme on Chemical Safety	5U01-000009	WORLD HEALTH ORGANIZATION	N	Y	\$90,000
FDA	Food Safety and Security Monitoring Project	Michigan Food Safety Task Force Meetings	SR13FD003066	MI ST DEPARTMENT OF AGRICULTURE	N	Y	\$8,750

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FDA	Health Promotion/Disease Prevention Program for American Indians and Alaska Natives	Nebraska Ruminant Feed Ban Support Project	1U18 FD003214	NE ST DEPARTMENT OF AGRICULTURE	N	Y	\$250,000
FDA	Health Promotion/Disease Prevention Program for American Indians and Alaska Natives	Office of the Texas State Chemist BSE Prevention Program	5U18 FD003215	TEXAS AGRICULTURAL EXPERIMENTAL STATION	N	Y	\$249,852
FDA	Health Promotion/Disease Prevention Program for American Indians and Alaska Natives	Minnesota Animal Feed Safety & BSE Prevention Program	5U18 FD003213	MN DEPT OF AGRIC.	N	Y	\$239,999
FDA	Ruminant Feed Ban Support Project	New Jersey AIDS Health Fraud Task Force	5R18FD003135	AFRICAN AMERICAN OFFICE OF GAY CONCERNS	N	Y	\$10,600
FDA	Ruminant Feed Ban Support Project	Hawaii Food Safety Task Force Conference on Model Food Code	5R13FD003187	HI ST DEPARTMENT OF HEALTH	N	Y	\$8,750
FDA	Ruminant Feed Ban Support Project	State Food Safety and Security Task Force Meetings	5R13FD003184	IN ST BOARD OF HEALTH	N	Y	\$8,750
FDA	Ruminant Feed Ban Support Project	State Food Safety and Food Security Task Force Meetings	5R13FD003188	NJ ST DEPARTMENT OF HEALTH AND SENIOR SERVICES	N	Y	\$8,750
FDA	Ruminant Feed Ban Support Project	Food Safety Task Force Meetings	5R13FD003180	OKLAHOMA DEPT OF AGRICULTURE	N	Y	\$8,750
FDA	Ruminant Feed Ban Support Project	PA Act 315 Meetings	5R13FD003191	PA DEPT OF AGRICULTURE	N	Y	\$8,750
FDA	Ruminant Feed Ban Support Project	West Virginia Food Safety and Food Security Task Force Meetings	5R13FD003183	WV ST DEPARTMENT OF HEALTH AND HUMAN RESOURCES	N	Y	\$8,750
FDA	State Health Fraud Task Force Grants	Florida Health Fraud Coalition	5R18FD002661	FLORIDA HEALTH FRAUD COALITION, INC	N	Y	\$15,000
FDA	State Health Fraud Task Force Grants	State Health Fraud Task Force Program	5R18FD002659	HELP THE PEOPLE PROGRAMS, INC	N	Y	\$15,000
FDA	State Health Fraud Task Force Grants	Health Fraud Task Force of California	5R18FD002650	INSTITUTE FOR THE ADVANCEMENT OF CRIMINAL JUSTICE	N	Y	\$15,000
FDA	State Health Fraud Task Force Grants	Colorado HIV/AIDS Treatment Task Force Annual Conference and Community Awards	5R18FD002648	JSI RESEARCH & TRAINING INSTITUTE, INC	N	Y	\$15,000
FDA	State Health Fraud Task Force Grants	New York State Health Fraud Task Force	5R18FD002656	KINGS COUNTY HOSPITAL CENTER	N	Y	\$15,000

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FDA	State Health Fraud Task Force Grants	Indiana Health Fraud Task Force	5R18FD002647	NATIONAL ASSOCIATION OF SOCIAL WORKERS, INDIANA CHAPTER	N	Y	\$15,000
FDA	State Health Fraud Task Force Grants	Kansas Food Safety Task Force	5R13FD002642	KS ST DEPARTMENT OF HEALTH & ENVIRONMENT	N	Y	\$8,750
FDA Total =							\$13,503,278

Health Resources and Services Administration (HRSA)						
HRSA	Emergency Communication Networks	Emergency Communication Networks	1 H2MCS07506-01-00	NC Community Health Center Association	Yes	\$666,665
HRSA	Emergency Communication Networks	Emergency Communication Networks	1 H2MCS07507-01-00	MISSISSIPPI PRIMARY HEALTH CARE ASSN	Yes	\$666,665
HRSA	Emergency Communication Networks	Emergency Communication Networks	1 H2MCS07508-01-00	ALABAMA PRIMARY HEALTH CARE ASSOC., INC.	Yes	\$666,665
HRSA	Emergency Communication Networks	Emergency Communication Networks	1 H2MCS07509-01-00	Florida Association of Community Health Centers, Inc.	Yes	\$666,665
HRSA	Emergency Communication Networks	Emergency Communication Networks	1 H2MCS07510-01-00	LOUISIANA PRIMARY CARE ASSN, INC.	Yes	\$666,665
HRSA	Emergency Communication Networks	Emergency Communication Networks	1 H2MCS07505-01-00	Texas Association of Community Health Centers, Inc.	Yes	\$663,269
HRSA	Poison Control and Stabilization and Enhancement Program	Poison Control and Stabilization and Enhancement Program	U4BHS07659	HOME SAFETY COUNCIL, WASHINGTON, DC	Yes	\$100,000
HRSA	State Planning Grants	State Planning Grants	1 P09HS07771-01-00	LOUISIANA DEPT OF HEALTH AND HOSPITALS	Yes	\$400,000
					HRSA Total =	\$4,496,594

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Indian Health Services (IHS)						
IHS	INDIANS INTO MEDICINE	INDIANS INTO MEDICINE	D919400180	UNIV OF ARIZONA	N	Y-LC
IHS	INDIANS INTO PSYCHOLOGY	INDIANS INTO PSYCHOLOGY	D94IHS00176	OK STATE UNIV	N	Y-LC
IHS	INDIANS INTO PSYCHOLOGY	INDIANS INTO PSYCHOLOGY	D919400144	UNIV OF MONTANA	N	Y-LC
IHS	INDIANS INTO PSYCHOLOGY	INDIANS INTO PSYCHOLOGY	D919400018	UNIV OF N DAKOTA	N	Y-LC
IHS	NATIONAL COUNCIL OF URBAN INDIAN HEALTH	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400012	NATIONAL COUNCIL OF URBAN HEALTH	N	Y-SS
IHS	NATIONAL INDIAN HEALTH BOARD	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400013	NATIONAL INDIAN HEALTH BOARD	N	Y-SS
IHS	NATIONAL NATIVE AMERICAN EMS ASSOCIATION	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400011	NATIONAL NATIVE AMERICAN EMS ASSOC.	N	Y-SS
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DIHS300134	INTER TRIBAL COUNCIL OF ARIZONA	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DIHS300095	CONFEDERATED SALISH & KOOTENAI	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DIHS300094	CALIFORNIA RURAL INDIAN HEALTH BOARD	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DIHS300093	ABERDEEN AREA TRIAL CHARMEN'S HEALTH BOARD	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DIHS300135	OK CITY AREA INTER-TRIBAL HEALTH BOARD	N	Y-LC
IHS	NATIVE AMERICAN RESEARCH	CLINICAL PREVENTION SERVICES	U269400019	NATIONAL ASSOC. OF COMM HEALTH REP	N	Y-SS
IHS	NURSING	NURSING PROGRAM	D91IHS300146	SAN DIEGO AMERICAN INDIAN HEALTH	N	Y-LC
IHS	NURSING	NURSING PROGRAM	D91IHS300145	LAKE COUNTY TRIBAL HEALTH CONSORTIUM	N	Y-LC
IHS	NURSING	NURSING PROGRAM	D91IHS300144	FIRST NATIONS COMMUNITY HEALTHSOURCE	N	Y-LC
IHS	NURSING	NURSING PROGRAM	D91IHS300143	SOUTHEAST ALASKA REGIONAL	N	Y-LC
IHS	NURSING	NURSING PROGRAM	D91IHS300142	UNITED AMERICAN INDIAN INVOLVEMENT	N	Y-LC

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IHS	NURSING	NURSING PROGRAM	D91IHS300140	NATIVE AMERICAN COMMUNITY HEALTH	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300138	LEECH LAKE RESERVATION	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300137	INDIAN HEALTH COUNCIL, INC	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300141	CHEROKEE NATION OF OKLAHOMA	N	Y-LC	\$99,929
IHS	NURSING	NURSING PROGRAM	D91IHS300136	HURON POTAWATOMI, INC	N	Y-LC	\$99,819
IHS	NURSING	NURSING PROGRAM	D91IHS300139	CHIPPEWA CREE TRIBE	N	Y-LC	\$99,706
IHS	TRIBAL MANAGEMENT	DEVELOPMENT GRANTS FOR IHS	D25IHS300111	ALASKA STATE TROOPERS	N	Y-SS	\$1,970,450
IHS	TRIBAL SELF GOVERNANCE	TRIBAL SELF-GOVERNANCE NEGOTIATION	U15IHS300083	SAC & FOX OF MISSISSIPPI	N	Y-LC	\$50,000
IHS	TRIBAL SELF GOVERNANCE	TRIBAL SELF-GOVERNANCE NEGOTIATION	U16IHS300082	PAWNEE TRIBE OF OKLAHOMA	N	Y-LC	\$20,000
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400507	NAVJO AREA IHS	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400480	RIVERSIDE-SAN BERNADINO	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400537	TOHONO OODHAM NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400518	IHS WHITERIVER SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400536	YAKAMA INDIAN HEALTH	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400445	ALBUQUERQUE SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400492	CHOCTAW NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400517	IHS UNITAH & OURAY SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400458	LEECH LAKE BAND	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400467	BLACKFEET	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400500	MUSCOGEE CREEK NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400491	CHICKASAW NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400512	COLORADO RIVER	N	Y-LC	\$397,100

FY 2007 Non-Competitive Grants

IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400495	HASKELL HEALTH CTR	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400486	MISSISSIPPI BAND OF CHOCTAW	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400484	UNITED INDIAN HEALTH SERVICE	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400444	SOUTHEAST REGIONAL HEALTH CONSORTIUM	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400442	SOUTHCENTRAL FOUNDATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400534	WARM SPRINGS HEALTH	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400449	PUEBLO OF ZUNI	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400498	LAWTON INDIAN PHS	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400527	COW CREEK BAND	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400541	PINE RIDGE IHS HOSPITAL	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400494	CHEROKEE NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400510	TUBA CITY REGIONAL	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400531	NW WASHINGTON IHB	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400450	RAMAH NAVAJO SCHOOL	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400446	SANTO DOMINGO	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400466	SAULT STE MARIE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400482	TOYABE INDIAN HEALTH	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400540	YUKON-KUSKOKWIM	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400438	WAGNER HEALTH CARE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400451	TAOS-PICURIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400489	ABSENTEE-SHAWNEE	N	Y-LC	\$324,300

FY 2007 Non-Competitive Grants

IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400433	BAD RIVER BAND	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400468	CONFEDERATED SALISH & KOOTENAI	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400516	HUALAPAI TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400496	INDIAN HEALTH CARE RESOURCE CENTER OF TULSA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400543	MILL LACS BAND	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400533	SEATTLE INDIAN HEALTH BOARD	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400470	FORT BLKNAP INDIAN COMMUNITY	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400478	INDIAN HEALTH COUNCIL	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400479	REDDING RACHERIA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HI D9400487	ST REGIS MOHAWK TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400523	BENEWAH MEDICAL CTR	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400431	CHEYENNE RIVER SIOUX	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400525	CONFEDERATED TRIBE OF CHEHALIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400524	COLVILLE CONFEDERATED TRIBES	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400542	FOND DU LAC RESERVATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400477	INDIAN HEALTH CENTER OF SANTA CLARA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400459	MEMONIE INDIAN TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400539	NORTON SOUND HEALTH CORP	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400473	ROCKY BOY HEALTH BOARD	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400448	PUEBLO OF SAN FELIPE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HI D9400532	QUINAUULT INDIAN NATION	N	Y-LC	\$324,300

FY 2007 Non-Competitive Grants

National Institutes of Health (NIH)						
NIH	CONFERENCE GRANTS	13TH WORLD CONGRESS ON BIOMEDICAL ALCOHOL RESEARCH	U13AA016254-01	RILEY EDWARD P. - SAN DIEGO STATE UNIVERSITY		\$213,515
NIH	CONFERENCE GRANTS	SOCIETY FOR PREVENTION RESEARCH ANNUAL MEETINGS	R13DA021047-05	BIGLAN ANTHONY - SOCIETY FOR PREVENTION RESEARCH, INC.		\$131,000
NIH	CONFERENCE GRANTS	24TH ANNUAL SYMPOSIUM ON NONHUMAN PRIMATE MODELS FOR AIDS	R13RR022961-01	ZOLA STUART M. - EMORY UNIVERSITY		\$73,089
NIH	CONFERENCE GRANTS	LINKING AFFECT TO ACTION: CRITICAL CONTRIBUTIONS OF THE ORBITOFONTAL CORTEX	R13DA021499-01	SCHOENBAUM GEOFFREY M. - NEW YORK ACADEMY OF SCIENCES		\$73,000
NIH	CONFERENCE GRANTS	KEYSTONE MEETINGS ON THE CELLULAR AND MOLECULAR BASIS OF METABOLIC DISORDERS	R13DK076500-01	ROBERTSON ANDREW D. - KEYSTONE SYMPOSIA		\$65,000
NIH	CONFERENCE GRANTS	ANNUAL MEETING OF THE NCR/NIBIB PRINCIPAL INVESTIGATORS	U13RR021994-01	LAKOWICZ JOSEPH R. - UNIVERSITY OF MARYLAND BALTIMORE		\$63,991
NIH	CONFERENCE GRANTS	NEUROBIOLOGY OF DISEASE IN CHILDREN CONFERENCES	R13NS040925-08	MARIA BERNARD L. - MEDICAL UNIVERSITY OF SOUTH CAROLINA		\$60,000
NIH	CONFERENCE GRANTS	CONFERENCE ON THE DIAGNOSIS OF MULTIPLE SYSTEM ATROPHY	R13NS055459-01	GILMAN SID - UNIVERSITY OF MICHIGAN AT ANN ARBOR		\$55,000
NIH	CONFERENCE GRANTS	37TH ANNUAL INTERNATIONAL NARCOTICS RESEARCH CONFERENCE	R13DA022176-01	BIDLACK JEAN M. - INTERNTL NARCOTICS RESEARCH CONF. INC.		\$50,000
NIH	CONFERENCE GRANTS	RESILIENCE IN CHILDREN	R13DA021053-01	LESTER BARRY M. - NEW YORK ACADEMY OF SCIENCES		\$50,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON DIETARY ASSESSMENT METHODS	R13CA112980-01A1	TAREN DOUGLAS L. - UNIVERSITY OF ARIZONA		\$49,961
NIH	CONFERENCE GRANTS	SOCIETY OF BEHAVIORAL MEDICINE ANNUAL MEETING & SCIENTIFIC SESSIONS	R13CA091918-06	GRAHAM AMANDA L. - SOCIETY OF BEHAVIORAL MEDICINE		\$49,891

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NIH	CONFERENCE GRANTS	AFMR-TRANSLATIONAL MEDICAL RESEARCH SYMPOSIA SERIES	R13R022326-01	ZUCKER DEBORAH - AMERICAN FEDERATION FOR MEDICAL RESEARCH			\$49,500
NIH	CONFERENCE GRANTS	IBANGS ANNUAL MEETING SUPPORT	R13AA016249-01	CRABBE JOHN C. - OREGON HEALTH & SCIENCE UNIVERSITY			\$49,500
NIH	CONFERENCE GRANTS	BETTER DECISIONS, BETTER CARE: THEORIES OF MEDICAL DECISION MAKING AND HEALTH	R13CA126359-01	REYNA VALERIE F. - CORNELL UNIVERSITY ITHACA			\$49,006
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCES OF THE SOCIETY FOR INTEGRATIVE ONCOLOGY	R13CA126426-01	JOHNSTONE PETER A S - EMORY UNIVERSITY			\$45,000
NIH	CONFERENCE GRANTS	NEW DIRECTIONS IN BIOLOGY AND DISEASE OF SKELETAL MUSCLE	R13NS055473-01	MCNALLY ELIZABETH M. - UNIVERSITY OF CHICAGO			\$40,000
NIH	CONFERENCE GRANTS	NORTH AMERICAN ASSOCIATION OF CENTRAL CANCER REGISTRIES	R13CA091824-06	HOWE HOLLY L. - NORTH AMERICAN ASSN/CENTRAL CANCER REG			\$37,512
NIH	CONFERENCE GRANTS	VIII INTERNATIONAL CONGRESS OF NEUROIMMUNOLOGY	R13NS056588-01	RAINE CEDRIC S. - YESHIVA UNIVERSITY			\$36,440
NIH	CONFERENCE GRANTS	SCIENTIFIC CONFERENCE ON MOEBIUS SYNDROME	R13NS056857-01	MCCARRELL VICKI - MOEBIUS SYNDROME FOUNDATION			\$36,000
NIH	CONFERENCE GRANTS	PSYCHOSOCIAL AND NEUROCOGNITIVE CONSEQUENCES OF CHILDHOOD CANCER	R13CA124117-01	PHIPPS SEAN - ST. JUDE CHILDREN'S RESEARCH HOSPITAL			\$33,000
NIH	CONFERENCE GRANTS	5TH INTERNATIONAL SYMPOSIUM ON HORMONAL CARCINOGENESIS	R13CA126366-01	LJONATHAN J. - UNIVERSITY OF KANSAS MEDICAL CENTER			\$32,661
NIH	CONFERENCE GRANTS	FASEB SUMMER RESEARCH CONFERENCE ON BIOLOGICAL METHYLATION	R13CA121747-01	CLARKE CATHERINE FREITAG - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$31,338
NIH	CONFERENCE GRANTS	2006 NF CONSORTIUM FOR NF1, NF2 AND SCHWANNOMATOSIS	R13NS056801-01	RAMESH VIJAYA - CHILDREN'S TUMOR FOUNDATION			\$30,500

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR RICKETTSIOLOGY CONFERENCE 2006	R13A071693-01	GANTA ROMAN R - KANSAS STATE UNIVERSITY		\$30,000
NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR VIROLOGY JUNIOR SCIENTIST TRAVEL REQUEST	R13A069676-01	GROSSBERG SIDNEY E - MEDICAL COLLEGE OF WISCONSIN		\$30,000
NIH	CONFERENCE GRANTS	HIV PATHOGENESIS	R13A068352-01	PARSLOW/TRISTRAM G - KEYSTONE SYMPOSIA		\$30,000
NIH	CONFERENCE GRANTS	HIV VACCINES	R13A068371-01	RUPRECHT RUTH M - KEYSTONE SYMPOSIA		\$30,000
NIH	CONFERENCE GRANTS	ICRS SYMPOSIUM ON THE CANNABINOIDS	R13DA016280-04	WILEY JENNY L - INTERNATIONAL CANNABINOID RESEARCH SOC		\$30,000
NIH	CONFERENCE GRANTS	RESEARCH SYMPOSIUM IN CLINICAL APHASIOLOGY	R13DC06295-04	TOMPKINS CONNIE A - UNIVERSITY OF PITTSBURGH AT PITTSBURGH		\$30,000
NIH	CONFERENCE GRANTS	FOLIC ACID, VITAMIN B12 AND ONE CARBON METABOLISM	R13DK076513-01	BANERJEE RUMA V - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$30,000
NIH	CONFERENCE GRANTS	AAT DEFICIENCY & LIVER DISEASES CAUSED BY PROTEINS	R13DK075247-01	TRAPNELL BRUCE C - ALPHA-1 FOUNDATION		\$30,000
NIH	CONFERENCE GRANTS	2006 NATIONAL NEUROTRAUMA SYMPOSIUM	R13NS056852-01	DEWITT DOUGLAS SCOTT - UNIVERSITY OF TEXAS MEDICAL BR GALVESTON		\$30,000
NIH	CONFERENCE GRANTS	ECONOMICS OF POPULATION HEALTH: AMERICAN SOCIETY OF HEALTH ECONOMICS CONF - NIDA	R13DA022098-01	SINDELAR JODY L - YALE UNIVERSITY		\$29,000
NIH	CONFERENCE GRANTS	13TH BIENNIAL FASEB SUMMER CONFERENCE ON RETINOIDS	R13DK075262-01	SOPRANO DIANNE R - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$29,000
NIH	CONFERENCE GRANTS	SYMPOSIUM ON SELENIUM IN BIOLOGY AND MEDICINE	R13DK075265-01	SUNDE ROGER A - UNIVERSITY OF WISCONSIN MADISON		\$28,500
NIH	CONFERENCE GRANTS	NOVEL TREATMENT FOR MUSCLE DISEASE: FUELING THE PIPELINE AND FINDING THE PRODUCT	R13NS056636-01	GRIGGS ROBERT C - UNIVERSITY OF ROCHESTER		\$28,000

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NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR NEUROCHEMISTRY: CELLULAR AND MOLECULAR MECHANISMS OF NEURAL	R13NS055474-01	MACKLIN WENDY B - AMERICAN SOCIETY FOR NEUROCHEMISTRY			\$27,500
NIH	CONFERENCE GRANTS	TRACE ELEMENT METABOLISM: BASIC AND APPLIED RESEARCH	R13DK075214-01	PETRIS MICHAEL J - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$26,000
NIH	CONFERENCE GRANTS	CONFERENCES ON EMERGING STATISTICAL ISSUES IN BIOMEDICAL RESEARCH	R13CA124365-01	LIN XIHONG - HARVARD UNIVERSITY (SCH OF PUBLIC HLTH)			\$25,000
NIH	CONFERENCE GRANTS	THE 2006 ADDICTION HEALTH SERVICES RESEARCH CONFERENCE	R13AA016857-01	BOOTH BRENDA M - UNIVERSITY OF ARKANSAS MED SCIS LTL ROCK			\$25,000
NIH	CONFERENCE GRANTS	LIVER DISEASE AND HIV	R13AI071925-01	SHERMAN KENNETH E - UNIVERSITY OF CINCINNATI			\$25,000
NIH	CONFERENCE GRANTS	ASM SUMMER INSTITUTE IN PREPARATION OF CAREERS IN MICROBIOLOGY - CYCLE 3	R13AI055488-04	PAYNE SHELLEY M - AMERICAN SOCIETY FOR MICROBIOLOGY			\$25,000
NIH	CONFERENCE GRANTS	23RD WORLD CONFERENCE OF THE WORLD FEDERATION OF THERAPEUTIC COMMUNITIES	R13DA020990-01	DEVILIN J CHARLES - DAYTOP VILLAGE			\$25,000
NIH	CONFERENCE GRANTS	DESIGN, ANALYSIS, & INTERPRETATION OF RCTS IN OBESITY	R13DK077555-01	ALLISON DAVID B - UNIVERSITY OF ALABAMA AT BIRMINGHAM			\$25,000
NIH	CONFERENCE GRANTS	IMPLEMENTING EVIDENCE-BASED DRUG TREATMENT IN CRIMINAL JUSTICE SETTINGS	R13DA022104-01	BELENKO STEVEN R - TREATMENT RESEARCH INSTITUTE, INC. (TRJ)			\$24,984
NIH	CONFERENCE GRANTS	ASM GENERAL MEETING MINORITY TRAVEL GRANT PROGRAM	R13AI066859-01	WUBAH DANIEL A - AMERICAN SOCIETY FOR MICROBIOLOGY			\$24,900
NIH	CONFERENCE GRANTS	CHRONIC LYME DISEASE: NEW STRATEGIES FOR INVESTIGATION, DIAGNOSIS AND THERAPY	R13NS056850-01	WITKOWSKI JAN A - COLD SPRING HARBOR LABORATORY			\$24,000
NIH	CONFERENCE GRANTS	THE 7TH INTERNATIONAL CONFERENCE ON PAIN & CHEMICAL DEPENDENCY	R13DA021472-01	PORTENOV RUSSELL K - BETH ISRAEL MEDICAL CTR (NEW YORK)			\$23,475

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NIH	CONFERENCE GRANTS	2006 SPIROCHETES, BIOLOGY OF GORDON RESEARCH CONFERENCE	R13A068380-01	HAAKE DAVID A - GORDON RESEARCH CONFERENCES			\$22,500
NIH	CONFERENCE GRANTS	2006 MOLECULAR BIOLOGY OF HEPATITIS B VIRUSES MEETING	R13A069829-01	YEN TIEN-SZE BENEDICT - HEPATITIS B FOUNDATION			\$22,000
NIH	CONFERENCE GRANTS	NEURAL-IMMUNE INTERACTIONS: PATHOLOGICAL MECHANISMS AND REPAIR	R13NS056810-01	WHITACRE CAROLINE C - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$22,000
NIH	CONFERENCE GRANTS	ANIMAL MODELS IN TYPE 1 DIABETES AND MULTIPLE SCLEROSIS	R13DK076554-01	VON HERRATH MATTHIAS G - NEW YORK ACADEMY OF SCIENCES			\$21,000
NIH	CONFERENCE GRANTS	AMERICAN ACADEMY OF CANCER EDUCATION ANNUAL MEETINGS - 2006, 2007, 2008	R13CA126454-01	VON GUNTEN CHARLES F - SAN DIEGO HOSPICE AND PALLIATIVE CARE			\$20,000
NIH	CONFERENCE GRANTS	NINTH AND TENTH NEW RESEARCHERS CONFERENCE FOR INVESTIGATORS IN PROBABILITY AND S	R13CA124120-01	HOFF PETER DAVID - UNIVERSITY OF WASHINGTON			\$20,000
NIH	CONFERENCE GRANTS	HMO RESEARCH NETWORK CONFERENCE	R13CA121760-01	GURWITZ JERRY H - UNIV OF MASSACHUSETTS MED SCH WORCESTER			\$20,000
NIH	CONFERENCE GRANTS	MOLECULAR MYCOLOGY SUMMER COURSE	R13AI056209-04	MITCHELL AARON P - MARINE BIOLOGICAL LABORATORY			\$20,000
NIH	CONFERENCE GRANTS	COMING TOGETHER TO OVERCOME HIV/AIDS IN ZIMBABWE AND ZAMBIA	R13AI069901-01	PADIAN NANCY S - UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$20,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CELIAC DISEASE SYMPOSIUM	R13DK078375-01	GREEN PETER - COLUMBIA UNIVERSITY HEALTH SCIENCES			\$20,000
NIH	CONFERENCE GRANTS	INTER-SOCIETY NUTRITION RESEARCH WORKSHOP	R13DK075229-01	TAPPENDEN KELLY A - AMERICAN DIETETIC ASSOCIATION			\$20,000
NIH	CONFERENCE GRANTS	AMERICAN SOCIETY FOR NEURAL THERAPY AND REPAIR	R13NS055615-01	SORTWELL CARYL E - UNIVERSITY OF CINCINNATI			\$20,000

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NIH	CONFERENCE GRANTS	ANNUAL UT-ORNL-KBRIN BIOINFORMATICS SUMMIT	R13LM009315-01	ROICHKA ERIC CHRISTIAN - UNIVERSITY OF LOUISVILLE			\$20,000
NIH	CONFERENCE GRANTS	XITH INTERNATIONAL SYMPOSIUM ON AMYLOIDOSIS	R13DK077562-01	SKINNER MARTHA M - BOSTON UNIVERSITY MEDICAL CAMPUS			\$19,700
NIH	CONFERENCE GRANTS	ASM CONFERENCE ON STREPTOCOCCAL GENETICS	R13A069883-01	BURNE ROBERT A - AMERICAN SOCIETY FOR MICROBIOLOGY			\$18,000
NIH	CONFERENCE GRANTS	ADVANCES IN INFLUENZA RESEARCH - FROM BIRDS TO BENCH TO BEDSIDE	R13A068379-01	WOODLAND DAVID L - KEYSTONE SYMPOSIA			\$18,000
NIH	CONFERENCE GRANTS	FASEB SUMMER RESEARCH CONFERENCE - POXVIRUSES	R13A069725-01	SHUMAN STEWART H - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$18,000
NIH	CONFERENCE GRANTS	DEVELOPMENT OF THE ENTERIC NERVOUS SYSTEM: CELLS & GENES	R13DK075207-01	GERSHON MICHAEL D - COLUMBIA UNIVERSITY HEALTH SCIENCES			\$18,000
NIH	CONFERENCE GRANTS	ALCOHOL & IMMUNOLOGY RESEARCH INTEREST GROUP MEETING	R13AA016751-01	KOVACS ELIZABETH J - LOYOLA UNIVERSITY CHICAGO			\$17,750
NIH	CONFERENCE GRANTS	2ND ANNUAL VACCINE RENAISSANCE CONFERENCE, RI	R13A069828-01A1	DE GROOT ANNE SEARLS - EPIVAX, INC.			\$17,500
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON PHOSPHOLIPASES	R13DK076501-01	ARM JONATHAN P - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$17,000
NIH	CONFERENCE GRANTS	ALCOHOL & IMMUNOLOGY RESEARCH INTEREST GROUP MEETING	R13AA016057-01	KOVACS ELIZABETH J - LOYOLA UNIVERSITY CHICAGO			\$16,250
NIH	CONFERENCE GRANTS	LIVER BIOLOGY /DEVELOPMENT /DISEASE FASEB CONFERENCE	R13DK076529-01	DARLINGTON GRETCHEN J - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$16,000
NIH	CONFERENCE GRANTS	LIPIDOMICS SESSION ISSFAL 2006	R13AA016509-01	BRENNAN JAMES T - CORNELL UNIVERSITY ITHACA			\$15,900
NIH	CONFERENCE GRANTS	13TH ANNUAL SPIRBM MEETING	R13CA126364-01	BUETTNER GARRY R - UNIVERSITY OF IOWA			\$15,000
NIH	CONFERENCE GRANTS	CSHL CONFERENCE ON PTEN PATHWAYS	R13CA121807-01	STEWART DAVID J - COLD SPRING HARBOR LABORATORY			\$15,000

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NIH	CONFERENCE GRANTS	CSHL SYMPOSIUM ON QUANTITATIVE BIOLOGY	R13CA119828-01	STILLMAN BRUCE W - COLD SPRING HARBOR LABORATORY				\$15,000
NIH	CONFERENCE GRANTS	NATIONAL CONFERENCE ON GRAM-POSITIVE PATHOGENESIS	R13A071613-01	BAYLES KENNETH W - UNIVERSITY OF NEBRASKA MEDICAL CENTER				\$15,000
NIH	CONFERENCE GRANTS	2006-2008 PALM SPRINGS SYMPOSIA ON HIV/AIDS	R13A068368-01	ROBINSON WILLIAM E - UNIVERSITY OF CALIFORNIA IRVINE				\$15,000
NIH	CONFERENCE GRANTS	NINTH INTERNATIONAL WORKSHOPS ON OPPORTUNISTIC PEOTISTS (IWOP-9)	R13A069741-01	KANESHIRO EDNA S - UNIVERSITY OF CINCINNATI				\$15,000
NIH	CONFERENCE GRANTS	2006 CELLULAR & MOLECULAR FUNGAL BIOLOGY GORDON RESEARCH CONFERENCE	R13A069831-01	MITCHELL AARON P - GORDON RESEARCH CONFERENCES				\$15,000
NIH	CONFERENCE GRANTS	PRIMARY IMMUNE DEFICIENCY CONSORTIUM CONFERENCE	R13A069762-01	CUNNINGHAM-RUNDLES CHARLOTTE - CLINICAL IMMUNOLOGY SOCIETY SYMPOSIA				\$15,000
NIH	CONFERENCE GRANTS	PAIN MECHANISMS AND THE DEVELOPMENT OF ANALGESICS	R13DA021484-01	YAKSH TONY L - KEYSTONE SYMPOSIA				\$15,000
NIH	CONFERENCE GRANTS	2ND INTERNATIONAL PATHOGENESIS OF RARE NEUROIMMUNOLOGIC DISORDERS	R13NS056854-01	KERR DOUGLAS A - JOHNS HOPKINS UNIVERSITY				\$15,000
NIH	CONFERENCE GRANTS	CONFERENCE ON UNSTABLE MICROSATELLITES & HUMAN DISEASE	R13NS056873-01	RANUM LAURA PW - UNIVERSITY OF MINNESOTA TWIN CITIES				\$15,000
NIH	CONFERENCE GRANTS	2006 GORDON RESEARCH CONFERENCE ON MOLECULAR AND CELLULAR NEUROBIOLOGY	R13NS055445-01	TSALIH-HUEI - GORDON RESEARCH CONFERENCES				\$15,000
NIH	CONFERENCE GRANTS	2006 MECHANISMS OF EPILEPSY AND NEURONAL SYNCHRONIZATION GORDON CONFERENCE	R13NS055624-01	STALEY KEVIN J - GORDON RESEARCH CONFERENCES				\$15,000
NIH	CONFERENCE GRANTS	AXON GUIDANCE, SYNAPTOGENESIS AND NEURAL PLASTICITY	R13NS055461-01	GRODZICKER TERRI L - COLD SPRING HARBOR LABORATORY				\$15,000

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NIH	CONFERENCE GRANTS	INTERNATIONAL MULTISPECIALTY CONFERENCE ON PDD AND DLB	R13NS054546-01	LIPPA CAROL F - DREXEL UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	MOVING TOWARD AXON PROTECTION AND REMYELINATION THERAPIES IN MAN	R13NS055464-01	COETZEE TIMOTHY J - NATIONAL MULTIPLE SCLEROSIS SOCIETY			\$15,000
NIH	CONFERENCE GRANTS	NEUROBIOLOGY OF DISEASE IN CHILDREN CONFERENCES	R13NS048177-03	WOOLSEY THOMAS A - WASHINGTON UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	ACADEMY OF MOLECULAR IMAGING 2006 ANNUAL MEETING	R13CA121776-01	GAMBIER SANJIV S - ACADEMY OF MOLECULAR IMAGING			\$14,000
NIH	CONFERENCE GRANTS	GORDON CONFERENCE ON "PHOSPHORYLATION AND G PROTEIN SIGNALING NETWORKS"	R13DK075259-01	AHN NATALIE G - GORDON RESEARCH CONFERENCES			\$14,000
NIH	CONFERENCE GRANTS	JOINT MEETING OF THE SOCIETY FOR LEUKOCYTE BIOLOGY (SLB) AND THE INTERNATIONAL EN	R13A071709-01	MOSSER DAVID M - SOCIETY FOR LEUKOCYTE BIOLOGY			\$13,500
NIH	CONFERENCE GRANTS	UBIQUITIN AND CELLULAR REGULATION	R13CA124292-01	HICKE LINDA A - FEDERATION OF AMER SOC FOR EXPR BIOLOGY			\$13,000
NIH	CONFERENCE GRANTS	2006 GLYCOLIPID & SPHINGOLIPID GORDON CONFERENCE	R13CA119831-01	MERRILL ALFRED H - GORDON RESEARCH CONFERENCES			\$13,000
NIH	CONFERENCE GRANTS	2006 BIOLOGY OF HOST-PARASITE INTERACTIONS GORDON RESEARCH CONFERENCE	R13A069719-01	ULLU ELISABETTA - GORDON RESEARCH CONFERENCES			\$13,000
NIH	CONFERENCE GRANTS	R13 TRAVEL GRANT FOR POLYAMINE/PARASITE CONFERENCE IN PORTLAND, OR	R13A071696-01	ULLMAN BUDDY - OREGON HEALTH & SCIENCE UNIVERSITY			\$12,541
NIH	CONFERENCE GRANTS	TOLERANCE, AUTOIMMUNITY AND IMMUNE REGULATION	R13A068401-01	SCOTT DAVID W - KEYSTONE SYMPOSIA			\$12,500
NIH	CONFERENCE GRANTS	FASEB CONFERENCE: TRANSPLANTATION IMMUNOLOGY	R13A069742-01	CHONG ANITA S - FEDERATION OF AMER SOC FOR EXPR BIOLOGY			\$12,500

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NIH	CONFERENCE GRANTS	8TH INTERNATIONAL SYMPOSIUM - SAGA OF THE GENUS BORDETELLA, 1906-2006	R13A073982-01	HEWLETT ERIC L - UNIVERSITY OF VIRGINIA CHARLOTTESVILLE		\$12,000
NIH	CONFERENCE GRANTS	CASE CFAR MEETING: HIV PATHOGENESIS	R13A071692-01	LEDERMAN MICHAEL M - CASE WESTERN RESERVE UNIVERSITY		\$12,000
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON MICROBIAL POLYSACCHARIDES	R13A069760-01	POWELL JAN L - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$12,000
NIH	CONFERENCE GRANTS	SIXTH INTERNATIONAL FOAMY VIRUS CONFERENCE	R13A069750-01	LINEAL MAXINE L - FRED HUTCHINSON CANCER RESEARCH CENTER		\$12,000
NIH	CONFERENCE GRANTS	VIRAL IMMUNITY: FROM BASIC MECHANISMS TO VACCINES	R13A068316-01	BLACKMAN MARCIA A - KEYSTONE SYMPOSIA		\$12,000
NIH	CONFERENCE GRANTS	2006 BACTERIAL CELL SURFACES GORDON RESEARCH CONFERENCE	R13A069717-01	YOUNG RYLAND F - GORDON RESEARCH CONFERENCES		\$12,000
NIH	CONFERENCE GRANTS	MOLECULAR BIOLOGY OF INTESTINAL LIPID TRANSPORT /METABOL	R13DK076398-01	PATEL SHAILENDRA BHANUBHAI - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$12,000
NIH	CONFERENCE GRANTS	STEM CELLS IN ORGAN MAINTENANCE AND REPAIR	R13DK077551-01	CANTLEY LLOYD G - YALE UNIVERSITY		\$12,000
NIH	CONFERENCE GRANTS	2006 MICROBIAL STRESS RESPONSE GORDON CONFERENCE	R13GM077793-01	KILEY PATRICIA J - GORDON RESEARCH CONFERENCES		\$12,000
NIH	CONFERENCE GRANTS	GLYCONJUGATE ANALYSIS WORKSHOP	U13RR024021-01	REINHOLD VERNON NYE - UNIVERSITY OF NEW HAMPSHIRE		\$11,999
NIH	CONFERENCE GRANTS	VIRULENCE MECHANISMS OF BACTERIAL PATHOGENS - INTERNATIONAL SYMPOSIUM	R13A071687-01A1	BROGDEN KIM A - UNIVERSITY OF IOWA		\$11,700
NIH	CONFERENCE GRANTS	2006 RACHMIEL LEVINE SYMPOSIUM - ADVANCES IN DIABETES RESEARCH: FROM CELL BIOLOGY	R13DK077564-01	KANDEEL FOUAD R - CITY OF HOPE/BECKMAN RESEARCH INSTITUTE		\$11,500
NIH	CONFERENCE GRANTS	ADVANCES IN NONTUBERCULOUS MYCOBACTERIAL RESEARCH	R13A066889-01A1	DALEY CHARLES L - NATIONAL JEWISH MEDICAL & RES CTR		\$11,058
NIH	CONFERENCE GRANTS	25TH IABCR CONGRESS CONFERENCE: PERSONALIZED BREAST CANCER THERAPY	R13CA124375-01	CARDIFF ROBERT D - UNIVERSITY OF CALIFORNIA DAVIS		\$11,000

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NIH	CONFERENCE GRANTS	2006 CHEMOTACTIC CYTOKINES GORDON CONFERENCE	R13A071484-01	LIRA SERGIO A - GORDON RESEARCH CONFERENCES			\$11,000
NIH	CONFERENCE GRANTS	2006 FASEB SRC ON LYMPHOCYTES AND ANTIBODIES	R13A071677-01	JENKINS MARC K - FEDERATION OF AMER SOC FOR EXPR BIOLOGY			\$11,000
NIH	CONFERENCE GRANTS	MEMBRANE ORGANISATION BY TETRASPANINS AND SMALL MULTI-TRANSMEMBRANE	R13A071671-01	SUN TUNG-TIEN - FEDERATION OF AMER SOC FOR EXPR BIOLOGY			\$11,000
NIH	CONFERENCE GRANTS	MALARIA: FUNCTIONAL GENOMICS TO BIOLOGY TO MEDICINE	R13A068319-01	WIRTH DYANN F - KEYSTONE SYMPOSIA			\$11,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE ON CALCIUM AND CELL FUNCTION	R13GM079049-01	LEWIS RICHARD S - FEDERATION OF AMER SOC FOR EXPR BIOLOGY			\$11,000
NIH	CONFERENCE GRANTS	REDISCOVERING B CELLS: A TRUDEAU INSTITUTE WORKSHOP	R13A071683-01	RANDALL TROY D - TRUDEAU INSTITUTE, INC.			\$10,913
NIH	CONFERENCE GRANTS	2006 MUTAGENESIS GORDON CONFERENCE	R13CA123797-01	JINKS-ROBERTSON SUE - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	2007 CAROTENIDS GORDON RESEARCH CONFERENCE	R13CA125876-01	LANDRUM JOHN THOMAS - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	XIIITH BIENNIAL MEETING OF THE SOCIETY FOR FREE RADICAL RESEARCH INTERNATIONAL	R13CA124282-01	CADENAS ENRIQUE - UNIVERSITY OF SOUTHERN CALIFORNIA			\$10,000
NIH	CONFERENCE GRANTS	VII INTERNATIONAL SKIN CARCINOGENESIS CONFERENCE (ISCC)	R13CA126683-01	FISCHER SUSAN M - UNIVERSITY OF TEXAS MD ANDERSON CAN CTR			\$10,000
NIH	CONFERENCE GRANTS	16TH CONGRESS OF THE INTERNATIONAL ORGANIZATION	R13A069730-01	KRAUSE DUNCAN C - UNIVERSITY OF GEORGIA (UGA)			\$10,000
NIH	CONFERENCE GRANTS	2006 GORDON RESEARCH CONFERENCE ON MICROBIAL TOXINS AND PATHOGENICITY	R13A069751-01	DIRITA VICTOR J - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	XLTH INTERNATIONAL SYMPOSIUM ON HUMAN CHLAMYDIAL INFECTIONS	R13A069761-01	SCHACHTER JULIUS - UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$10,000

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NIH	CONFERENCE GRANTS	2006 ALA/SEBIR SUMMER RESEARCH CONFERENCE "UROTHELIAL BIOLOGY & BLADDER CANCER"	R13DK077560-01	BORLING DALE E - AMERICAN UROLOGICAL ASSOCIATION			\$10,000
NIH	CONFERENCE GRANTS	6TH INTERNATIONAL PODOCYTE CONFERENCE	R13DK076506-01	SHANKLAND STUART - UNIVERSITY OF WASHINGTON			\$10,000
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON THE DYNAMIC STRUCTURE OF THE NUCLEAR HORMONE RECEPTORS	R13DK076503-01	THOMPSON E B - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$10,000
NIH	CONFERENCE GRANTS	HINXTON RETREAT WORKSHOP ON MEMBRANOPROLIFERATIVE GLOMERULONEPHRITIS TYPE II	R13DK077416-01	SMITH RICHARD J - UNIVERSITY OF IOWA			\$10,000
NIH	CONFERENCE GRANTS	PATHOGENESIS OF OBESITY AND METABOLIC SYNDROME	R13DK076499-01	HORTON JAY D - UNIVERSITY OF TEXAS SW MED CTR/DALLAS			\$10,000
NIH	CONFERENCE GRANTS	SATELLITE SYMPOSIUM TO THE ASGT ANNUAL MEETING	R13DK076317-01	WILSON JAMES M - UNIVERSITY OF PENNSYLVANIA			\$10,000
NIH	CONFERENCE GRANTS	THE 10TH SYMPOSIUM OF THE INTERNATIONAL DIABETES EPIDEMIOLOGY GROUP	R13DK077547-01	REWERS MARIAN J - UNIVERSITY OF COLORADO DENVER/HSC AURORA			\$10,000
NIH	CONFERENCE GRANTS	GASTROINTESTINAL EOSINOPHIL RESEARCH SYMPOSIUM	R13DK076672-01	FURUTA GLENN T - CHILDREN'S HOSPITAL BOSTON			\$10,000
NIH	CONFERENCE GRANTS	EXPERIMENTAL APPROACHES TO UNDERSTANDING THE ENS AND ITS DISORDERS	R13DK075226-01	GALLIGAN JAMES J - MICHIGAN STATE UNIVERSITY			\$10,000
NIH	CONFERENCE GRANTS	2006 TETRAPYRROLES CHEMISTRY AND BIOLOGY OF GORDON RESEARCH CONFERENCE	R13DK075228-01	SMITH ANN - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON COMPLEXITY IN ACUTE ILLNESS	R13GM072437-03	CLERMONT GILLES - UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$10,000

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NIH	CONFERENCE GRANTS	PROTEIN FOLDING IN THE CELL	R13GM079041-01	MORIMOTO RICHARD L - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$10,000
NIH	CONFERENCE GRANTS	BIOPAX - BIOLOGICAL PATHWAY COMMUNITY WORKSHOP	R13GM076939-01	SANDER CHRIS - SLOAN- KETTERING INSTITUTE FOR CANCER RES			\$10,000
NIH	CONFERENCE GRANTS	SYSTEMS BIOLOGY: INTEGRATING BIOLOGY, TECHNOLOGY	R13GM077016-01	ADEREM ALAN A - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	12TH INTERNATIONAL WORKSHOP ON ATAXIA-TELANGIECTASIA AND ATM	R13NS056882-01	GATTI RICHARD A - UNIVERSITY OF CALIFORNIA LOS ANGELES			\$10,000
NIH	CONFERENCE GRANTS	16TH BIENNIAL MEETING OF THE INTERNATIONAL SOCIETY FOR DEVELOPMENTAL NEUROBIOLOGY	R13NS056849-01	LEVITT PAT R - VANDERBILT UNIVERSITY			\$10,000
NIH	CONFERENCE GRANTS	MOLECULAR MECHANISMS OF NEURODEGENERATION SCIENTIFIC CONFERENCE	R13NS056841-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	TRANSLATIONAL NEURAL ENGINEERING: MULTIPLE PERSPECTIVES	R13NS058238-01	ROUSCHE PATRICK J - UNIVERSITY OF ILLINOIS AT CHICAGO			\$10,000
NIH	CONFERENCE GRANTS	VIIITH INTERNATIONAL CONFERENCE ON BRAIN ENERGY METABOLISM	R13NS056861-01	SWANSON RAYMOND A - NORTHERN CALIFORNIA INSTITUTE RES & EDUC			\$10,000
NIH	CONFERENCE GRANTS	2006 MYELIN GORDON CONFERENCE	R13NS055638-01	MILLER ROBERT H - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	PROTEIN MISFOLDING DISEASES	R13NS054459-01	KELLY JEFFERY W - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	SOCIETY FOR RESEARCH ON BIOLOGICAL RHYTHMS MEETING	R13NS055598-01	GREEN CARLA B - UNIVERSITY OF VIRGINIA CHARLOTTESVILLE			\$10,000
NIH	CONFERENCE GRANTS	TARGETING ADENOSINE A2A RECEPTORS IN PARKINSON'S DISEASE	R13NS055597-01	SCHWARZSCHILD MICHAEL A MASSACHUSETTS GENERAL HOSPITAL			\$10,000
NIH	CONFERENCE GRANTS	IMMUNOLOGICAL INTERVENTION IN HUMAN DISEASE SCIENTIFIC CONFERENCE	R13A071685-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$9,527

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	JAKS, STATS AND IMMUNITY SCIENTIFIC CONFERENCE	R13A071686-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$9,527
NIH	CONFERENCE GRANTS	MAST CELLS, BASOPHILS, AND ICE: HOST DEFENSE AND DISEASE SCIENTIFIC CONFERENCE	R13A071684-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$9,527
NIH	CONFERENCE GRANTS	CHEMICAL GLYCOBIOLOGY SYMPOSIUM	R13A073074-01	CHEN XI - UNIVERSITY OF CALIFORNIA DAVIS			\$9,499
NIH	CONFERENCE GRANTS	FOURTEENTH MICROBIAL GENOMICS CONFERENCE-2006	R13A071706-01	MILLER JEFFREY H - UNIVERSITY OF CALIFORNIA LOS ANGELES			\$9,000
NIH	CONFERENCE GRANTS	QUANTITATIVE CHEMICAL BIOLOGY - METHODS TO ANALYZE CELLULAR PROCESSES	R13DA020998-01	WEBER STEPHEN - UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$9,000
NIH	CONFERENCE GRANTS	SOUTH EAST NERVE NET CONFERENCE	R13NS043190-04A1	KATZ PAUL S - GEORGIA STATE UNIVERSITY			\$9,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM ON PLASMAID BIOLOGY	R13A069743-01	KADO CLARENCE T - UNIVERSITY OF CALIFORNIA DAVIS			\$8,800
NIH	CONFERENCE GRANTS	REGULATION & FUNCTION OF SMALL GTPASES	R13CA124244-01	COX ADRIENNE D - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$8,000
NIH	CONFERENCE GRANTS	THE 6TH ORFOME MEETING: ORFOMES AND SYSTEMS	R13CA126361-01	HILL DAVID E - DANA- FARBER CANCER INSTITUTE			\$8,000
NIH	CONFERENCE GRANTS	EPIGENETICS AND CHROMATIN REMODELING	R13CA117385-01	PARO RENATO - KEYSTONE SYMPOSIA			\$8,000
NIH	CONFERENCE GRANTS	THE 8TH VALENCIE/ISBA WORLD MEETING ON BAYESIAN STATISTICS	R13CA121754-01	GELFAND ALAN E - DUKE UNIVERSITY			\$8,000
NIH	CONFERENCE GRANTS	MEETING ON THE PATHOGENESIS OF CLOSTRIDIA	R13A069884-01	SONENSHIN ABRAHAM LINCOLN - TUFTS UNIVERSITY BOSTON			\$8,000
NIH	CONFERENCE GRANTS	NEURAL CONTROL OF ABNORMAL MOVEMENT	R13NS055614-01	SANGER TERENCE D - STANFORD UNIVERSITY			\$8,000
NIH	CONFERENCE GRANTS	METAL CARCINOGENESIS: NEW CONCEPTS	R13CA124263-01	ZHITKOVICH ANATOLY - BROWN UNIVERSITY			\$7,939
NIH	CONFERENCE GRANTS	ALLERGY, ALLERGIC INFLAMMATION AND ASTHMA	R13A068367-01	VERCELLI DONATA - KEYSTONE SYMPOSIA			\$7,500

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	DEGENERACY AND COMPLEXITY IN THE IMMUNE SYSTEM	R13A068354-01	SERCARZ ELLE - TORREY PINES INST FOR MOLECULAR STUDIES			\$7,500
NIH	CONFERENCE GRANTS	GAMMA DELTA T CELL CONFERENCE	R13A068398-01	HAVKAN WENDY L - SCRIPPS RESEARCH INSTITUTE			\$7,500
NIH	CONFERENCE GRANTS	LYMPHOCYTE ACTIVATION AND SIGNALING	R13A068311-01	KORETZKY GARY A. - KEYSTONE SYMPOSIA			\$7,500
NIH	CONFERENCE GRANTS	10TH CONGRESS: INTERNATIONAL SOCIETY OF DEVELOPMENTAL AND COMPARATIVE IMMUNOLOGY	R13A069720-01	WARR GREGORY W - MEDICAL UNIVERSITY OF SOUTH CAROLINA			\$7,500
NIH	CONFERENCE GRANTS	2006 CANCER MODEL MECHANISMS	R13CA124261-01	KAEJIN WILLIAM G - GORDON RESEARCH CONFERENCES			\$7,000
NIH	CONFERENCE GRANTS	ASA 2006 CONFERENCE ON RADIATION AND HEALTH	R13CA121911-01	SMITH WILLIAM B - AMERICAN STATISTICAL ASSOCIATION			\$7,000
NIH	CONFERENCE GRANTS	THE FOURTH INTERNATIONAL CONGRESS ON ELECTRON TOMOGRAPHY	R13GM077866-01	ELLISMAN MARK H - UNIVERSITY OF CALIFORNIA SAN DIEGO			\$7,000
NIH	CONFERENCE GRANTS	NEUROMECHANICS: AN INTERDISCIPLINARY APPROACH FOR UNDERSTANDING MOTOR CONTROL	R13NS055623-01	BIEWENER ANDREW A - HARVARD UNIVERSITY			\$7,000
NIH	CONFERENCE GRANTS	ADVANCING CANCER CARE IN THE ELDERLY: HEMATOLOGICAL CANCERS 2006; PIECING THE PUZ	R13CA124592-01	ERSHLER WILLIAM - GERIATRIC ONCOLOGY CONSORTIUM			\$6,000
NIH	CONFERENCE GRANTS	9TH INTERNATIONAL WORKSHOP ON "RADIATION DAMAGE TO DNA"	R13CA121703-01	WALLACE SUSAN S - UNIVERSITY OF VERMONT & ST AGRIC COLLEGE			\$6,000
NIH	CONFERENCE GRANTS	CELL BIOLOGY OF VIRUS ENTRY, REPLICATION AND PATHOGENESIS	R13A066899-01	VIRGIN HERBERT W - KEYSTONE SYMPOSIA			\$6,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE ON VIRUS ASSEMBLY	R13A069885-01	PREVELIGE PETER E - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$6,000

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON MOLECULAR BIOPHYSICS OF CELLULAR MEMBRANES	R13GM079042-01	SMITH STEVEN OWEN - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$5,250
NIH	CONFERENCE GRANTS	11TH & 12TH CONFERENCE ON CANCER THERAPY WITH ANTIBODIES AND IMMUNOCONJUGATES	R13CA124279-01	GOLDENBERG DAVID M - CTR FOR MOLECULAR MEDICINE/IMMUNOLOGY			\$5,000
NIH	CONFERENCE GRANTS	2006 MOLECULAR THERAPEUTICS OF CANCER GORDON RESEARCH CONFERENCE	R13CA124132-01	EASTMAN ALAN R - GORDON RESEARCH CONFERENCES			\$5,000
NIH	CONFERENCE GRANTS	ANNUAL PRIMARY CNS LYMPHOMA COLLABORATIVE GROUP MEETING	R13CA124293-01	BATCHELOR TRACY T - MASSACHUSETTS GENERAL HOSPITAL			\$5,000
NIH	CONFERENCE GRANTS	CONFERENCE GRANT: "DNA ALKYLATION: FROM NATURAL PRODUCTS TO CHEMOTHERAPY"	R13CA123967-01	GATES KENT S - UNIVERSITY OF MISSOURI-COLUMBIA			\$5,000
NIH	CONFERENCE GRANTS	DNA REPLICATION AND GENOME INTEGRITY	R13CA124281-01	WEITZMAN MATTHEW D. - SALK INSTITUTE FOR BIOLOGICAL STUDIES			\$5,000
NIH	CONFERENCE GRANTS	LOUISVILLE BREAST CANCER UPDATE	R13CA124224-01	CHAGPAR ANEES B - UNIVERSITY OF LOUISVILLE			\$5,000
NIH	CONFERENCE GRANTS	OVARIAN CANCER NATIONAL ALLIANCE'S 9TH ANNUAL CONFERENCE	R13CA124382-01	SALWAY BLACK SHERRY - OVARIAN CANCER NATIONAL ALLIANCE			\$5,000
NIH	CONFERENCE GRANTS	ACTIVE SURVEILLANCE FOR EARLY STAGE PROSTATE CANCER: SELECTION, MONITORING	R13CA121759-01	CARROLL PETER R - UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$5,000
NIH	CONFERENCE GRANTS	ANNUAL SAN ANTONIO BREAST CANCER SYMPOSIUM	R13CA119860-01	COLTMAN CHARLES A - UNIVERSITY OF TEXAS HLTH SCI CTR SAN ANT			\$5,000
NIH	CONFERENCE GRANTS	REGIONAL CANCER CENTER CONSORTIUM ANNUAL MEETINGS	R13CA115173-01A1	REPASKY ELIZABETH A - ROSWELL PARK CANCER INSTITUTE CORP			\$5,000
NIH	CONFERENCE GRANTS	REGULATION OF EUKARYOTIC TRANSCRIPTION-CHROMATIN TO MRNA	R13CA119826-01	GOODRICH JAMES - KEYSTONE SYMPOSIA			\$5,000

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	2006 THIOL-BASED REDOX REGULATION AND SIGNALING GORDON RESEARCH CONFERENCE	R13CA121806-01	GLADYSHEV YADIM N. - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	DNA DAMAGE, MUTATION AND CANCER GORDON CONFERENCE	R13CA121756-01	HAYS JOHN B. - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	EUGENE P. CRONKITE SYMPOSIUM	R13CA19890-01	DANIAK NICHOLAS J. - BRIDGEPORT HOSPITAL		\$5,000
NIH	CONFERENCE GRANTS	UBIQUITIN/CANCER: MOLECULAR TARGETS/MECHANISMS TO CLINIC	R13CA119823-01	JOAZEIRO CLAUDIO A.P. - AMERICAN ASSOCIATION FOR CANCER RESEARCH		\$5,000
NIH	CONFERENCE GRANTS	IMMUNOLOGY INTERNATIONAL CONFERENCE "CORRELATES OF DISEASE PROGRESSION IN AFRICA"	R13A071813-01	CAO HUYEN L. - PUBLIC HEALTH FOUNDATION ENTERPRISES		\$5,000
NIH	CONFERENCE GRANTS	NF-KAPPA B	R13A068378-01	ISRAEL ALAIN - KEYSTONE SYMPOSIA		\$5,000
NIH	CONFERENCE GRANTS	BACTERIAL INVASION & PHAGOCYTOSIS	R13A069899-01	FALKE JOSEPH J. - SOCIETY OF GENERAL PHYSIOLOGISTS		\$5,000
NIH	CONFERENCE GRANTS	AMPK: IMPACT ON METABOLISM AND DISEASE	R13DK076518-01	GOODYEAR LAURIE J. - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$5,000
NIH	CONFERENCE GRANTS	SCIENTIFIC MEETING	R13DK078376-01	VERFAILLIE CATHERINE M. - INTERNATIONAL SOCIETY/EXPER HEMATOLOGY		\$5,000
NIH	CONFERENCE GRANTS	WOMEN IN NEPHROLOGY PROFESSIONAL DEVELOPMENT SEMINAR	R13DK077550-01	PASTOR-SOLER NURIA M. - UNIVERSITY OF PITTSBURGH AT PITTSBURGH		\$5,000
NIH	CONFERENCE GRANTS	2006 BIOPHYSICAL DISCUSSIONS - MOLECULAR MOTORS: POINT COUNTERPOINT	R13GM079117-01	ROSENFELD STEVEN S. - BIOPHYSICAL SOCIETY		\$5,000
NIH	CONFERENCE GRANTS	UNDERSTANDING COMPLEX SYSTEMS 2006	R13GM079069-01	HUBLER ALFRED W. - UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN		\$5,000
NIH	CONFERENCE GRANTS	2006 SINGLE MOLECULE APPROACHES TO BIOLOGY	R13GM077791-01	XIE SUNNEY - GORDON RESEARCH CONFERENCES		\$5,000

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON CELL AND MOLECULAR BIOLOGY OF CHLAMYDOMONAS	R13GM077779-01	DUTCHER SUSAN K - GENETICS SOCIETY OF AMERICA		\$5,000
NIH	CONFERENCE GRANTS	LIPID RAFTS AND CELL FUNCTION	R13GM076901-01	PIKE LINDA J - KEYSTONE SYMPOSIA		\$5,000
NIH	CONFERENCE GRANTS	STRUCTURE BASED DRUG DISCOVERY	R13GM076892-01	BURLEY STEPHEN K - KEYSTONE SYMPOSIA		\$5,000
NIH	CONFERENCE GRANTS	2006 DIFFRACTION METHODS IN STRUCTURAL BIOLOGY CONFERENCE	R13GM077861-01	ADAMS PAUL DAVID - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	GRC MACROMOLECULAR ORGANIZATION & CELL FUNCTION	R13GM077794-01	LYNCH RONALD M - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	CSHL CONFERENCE ON MECHANISMS AND MODELS OF CANCER	R13CA121749-01	STEWART DAVID J - COLD SPRING HARBOR LABORATORY		\$4,662
NIH	CONFERENCE GRANTS	CSHL CONFERENCE ON THE CELL CYCLE	R13CA119850-01	GRODZICKER TERRIL - COLD SPRING HARBOR LABORATORY		\$4,000
NIH	CONFERENCE GRANTS	TRANSATLANTIC FRONTIERS OF CHEMISTRY	R13GM079045-01	NAMEROFF TAMARA JULIA - AMERICAN CHEMICAL SOCIETY		\$4,000
NIH	CONFERENCE GRANTS	UNDERSTANDING THE IMPACT OF MULTIPLE SYMPTOMS: A SYMPTOM BURDEN CONSORTIUM	R13CA124366-01	CLEELAND CHARLES S - UNIVERSITY OF TEXAS MD ANDERSON CAN CTR		\$3,000
NIH	CONFERENCE GRANTS	2006 PROTEOLYTIC ENZYMES AND THEIR INHIBITORS GORDON CONFERENCE	R13CA121705-01	BLACK ROY A - GORDON RESEARCH CONFERENCES		\$3,000
NIH	CONFERENCE GRANTS	CONFERENCE PROPOSAL: FASEB NUCLEIC ACID ENZYMES	R13CA121808-01	STODDARD BARRY L - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$3,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM ON THE COMPARATIVE BIOLOGY OF THE ALPHA-PROTEOBACTERIA	R13A071946-01	SOBRAI BRUNO - VIRGINIA POLYTECHNIC INST AND ST UNIV		\$3,000
NIH	CONFERENCE GRANTS	2006 METALS IN MEDICINE GORDON RESEARCH CONFERENCE	R13GM078843-01	FRANKLIN SONYA J - GORDON RESEARCH CONFERENCES		\$3,000

FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	ENZYMES, COENZYMES, METABOLIC PATHWAYS GRC	R13GM079040-01	BOOKER SQUIRE J - GORDON RESEARCH CONFERENCES			\$3,000
NIH	CONFERENCE GRANTS	2006 MOLECULAR & CELLULAR BIOENERGETICS GORDON CONFERENCE	R13GM077880-01	DUNN STANLEY D - GORDON RESEARCH CONFERENCES			\$2,000
NIH	CONFERENCE GRANTS	NUCLEIC ACIDS GORDON RESEARCH CONFERENCE	R13GM077809-01	STROBEL SCOTT A - GORDON RESEARCH CONFERENCES			\$2,000
NIH Total =							\$3,858,305

FY 2007 Non-Competitive Grants

Office of Disease Prevention and Health Promotion (ODPHP)						
ODPHP	Disease Prevention and Health Promotion	2006 Institute of Medicine	IOMHP060002	National Academy of Sciences	N	Y - multi year funding
ODPHP	Disease Prevention and Health Promotion	University Of Arkansas For Medical Sciences	ATPHP060002	University of Arkansas for Medical Sciences	N	Y
ODPHP Total =						\$1,415,009

FY 2007 Non-Competitive Grants

Office of Global Health Affairs (OGHA)						
OGHA	Infectious Disease Surveillance networks	2006 Support, Training and Capacity Building for Infectious Disease Surveillance Networks	IDSEP060001	Pasteur Foundation	N	Y - multi year funding \$3,443,606
OGHA	Infectious Disease Surveillance networks	Gorgas Memorial Institute of Health Studies	IDSEP060003	Gorgas Memorial Institute of Health Studies	N	Y - multi year funding \$3,100,000
OGHA	Infectious Disease Surveillance networks	Gorgas Memorial Institute of Health Studies	IDSEP060002	Gorgas Memorial Institute of Health Studies	N	Y - multi year funding \$1,477,000
OGHA	Influenza Vaccines (World Health Organization)	2006 International Development of H5N1 Influenza Vaccines (World Health Organization)	IDSEP060004	World Health Organization	N	Y \$10,000,000
OGHA	National Strategy for Pandemic Influenza	2006 GHS Emerging Infectious Diseases in the Asia-Pacific Region (REDI)	GHSUGH060009	Regional Emerging Diseases Intervention (REDI) Centre	N	Y - multi year funding \$2,680,000
OGHA	National Strategy for Pandemic Influenza	2006 GHS Avian and Pandemic Influenza (Libyan Arab Jamahiriya)	GHSUGH060010	National Center Infectious Disease Prevention Control	N	Y - multi year funding \$1,250,000
OGHA	Strengthening the Management and Services of the Women's and Children's Hospitals in Kabul	2006 Technical Assistance and Support (Afghan Ministry of Public Health)	GHSUGH060008	Islamic Republic of Afghanistan Ministry of Public Health	N	Y \$1,750,000
OGHA	US - Mexico Border Health Commission Program	2006 Global Health Services Mexican Outreach Offices (Single Eligibility Only)	GHSUGH060007	US-Mexico Foundation for Science (FUMEC)	N	Y - multi year funding \$1,350,000
OGHA	US - Mexico Border Health Commission Program	Texas Outreach Office of the United States - Mexico Border	GHSUGH000004	Texas Department of State Health Services	N	Y - multi year funding \$977,500
OGHA	US - Mexico Border Health Commission Program	2006 Public Health Services at the New Mexico - Chihuahua Border	GHSUGH000003	New Mexico Department of Health	N	Y - multi year funding \$596,267
OGHA	US - Mexico Border Health Commission Program	California Outreach Office to the United States/Mexico Border Health Commission California - Baja California Border	GHSUGH000005	California Department of Health Services	N	Y - multi year funding \$524,083
OGHA	US - Mexico Border Health Commission Program	Cooperative Agreement to the Arizona Outreach Office to Strengthen Public Health Services at the Arizona Border	GHSUGH000002	ARIZONA DEPARTMENT OF HEALTH SERVICES	N	Y - multi year funding \$518,167
OGHA Total =						\$27,666,623

FY 2007 Non-Competitive Grants

Office of Minority Health (OMH)					
OMH	Minority Health Cooperative Agreements	OMH 2006 Directed Umbrella Cooperative Agreement	MFCMP061011	Morehouse School of Medicine	N
				Y - multi year funding	\$4,270,000
OMH Total =					\$4,270,000

FY 2007 Non-Competitive Grants

Office of the Surgeon General (OSG)					
OSG	Surgeon General's Medical Reserve Corps	MRC Capacity Development Project	MRCSG061001	National Association of County and City Health Officials	N
				Y - multi year funding	\$14,225,000
OSG Total =					\$14,225,000

FY 2007 Non-Competitive Grants

Substance Abuse and Mental Health Services Administration (SAMHSA)					
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	Kansas Data Infrastructure Grant for Quality Improvement	SM56615-03	Kansas Dept of Social & Rehab Service	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State DIG Supplemental: Mental Health and Stigma	SM56618-03	Vermont State Dept. of Mental Health	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	Maine Data Infrastructure Grant Project	SM56620-03	State of Maine	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grant for Quality Improvement	SM56622-03	MISSOURI STATE DEPT OF MENTAL HEALTH	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grant	SM56626-03	VIRGINIA ST DEPT OF MH/MR/SUB ABUSE SRVS	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	Colorado Mental Health Data Infrastructure Grant	SM56632-03	Colorado Department of Human Services	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State of Montana Data Infrastructure Development Program	SM56634-03	Mental Health Services Bureau	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	Utah Mental Health Data Quality Improvement Project	SM56635-03	UTAH STATE DEPARTMENT OF HUMAN SERVICES	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grant	SM56637-03	District of Columbia Dept of Mental Hlth	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grants for Quality Improvement Program	SM56638-03	State of New Hampshire	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grant for Quality Improvement	SM56639-03	Wisconsin Dept of Hlth & Family Services	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grant	SM56640-03	Commonwealth of Massachusetts	\$14,500
SAMHSA	State Mental Health Data Infrastructure Grants - Supplement	State Mental Health Data Infrastructure Grants for Quality	SM56643-03	Texas Dept of State Health Services	\$14,500

FY 2007 Non-Competitive Grants

OPBIV	Program Title	Grant Title	Grant Award #	Grantee Name	Unsolicted (Y/N)	Sole Source/ Limited Competition (Y/N)	Award Amount
Administration for Children and Families (ACF)							
ACF	ACYFYSB	Non-Competitive					
ACF	OCSE	Section 1115	90XF0035	The Medical Institute for Sexual Health	Y	N	\$207,400
ACF	OCSE	Section 1115	90FD0121	MD Department of Human Resources			\$150,000
ACF	OCSE	Section 1115	90FD0122	NJ Division of Family Development			\$150,000
ACF	OCSE	Section 1115	90FD0111	CO Department of Human Services			\$125,579
ACF	OCSE	SIP	90F0086	TX Family Service Association			\$125,000
ACF	OCSE	SIP	90F0087	Child and Family Resource Council, Kent County, MI			\$124,898
ACF	OCSE	SIP	90F0085	Center for Policy Research, Denver, CO			\$124,820
ACF	OCSE	Section 1115	90FD0105	WI Department of Workforce Development			\$108,400
ACF	OCSE	Section 1115	90FD0110	HI Child Support Enforcement Agency			\$108,400
ACF	OCSE	Section 1115	90FD0113	TX Office of Attorney General			\$108,400
ACF	OCSE	Section 1115	90FD0109	MD Department of Human Resources			\$102,414
ACF	OCSE	Section 1115	90FD0108	TN Department of Human Services			\$100,686
ACF	OCSE	SIP	90F0070	The Fathers' Support Center, St. Louis, MO			\$100,000
ACF	OCSE	SIP	90F0076	Families Under Urban and Social Attack, TX			\$100,000
ACF	OCSE	SIP	90F0077	AL Child Abuse and Neglect Prevention Board, The Children's Trust Fund			\$100,000
ACF	OCSE	SIP	90F0088	Kern County, CA, Department of Child Support Services			\$100,000
ACF	OCSE	SIP	90F0091	TX Office of the Attorney General			\$100,000
ACF	OCSE	SIP	90F0093	Cuyahoga County, OH, Prosecutor's Office			\$100,000

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FY 2007 Non-Competitive Grants

ACF	OCSE	SIP	90FD0071	Michigan State University				\$99,952
ACF	OCSE	SIP	90FD0089	Shoalwater Bay Indian Tribe				\$99,896
ACF	OCSE	SIP	90FD0092	NY State Unified Court System				\$99,830
ACF	OCSE	SIP	90FD0069	South Baton Rouge Christian Children's Foundation of LA				\$98,962
ACF	OCSE	Section 1115	90FD0107	WA State Department Social and Health Services				\$91,390
ACF	OCSE	SIP	90FD0090	Sagamore Institute, Inc., IN				\$83,498
ACF	OCSE	Section 1115	90FD0114	CA Department of Child Support Services				\$75,000
ACF	OCSE	Section 1115	90FD0115	CO Department of Human Services				\$75,000
ACF	OCSE	Section 1115	90FD0119	DC, Office of the Attorney General				\$65,000
ACF	OCSE	Section 1115	90FD0116	MD Department of Human Resources				\$64,998
ACF	OCSE	Section 1115	90FD0118	ND Department of Human Services				\$60,000
ACF	OCSE	Section 1115	90FD0120	DC, Office of the Attorney General				\$60,000
ACF	OCSE	Section 1115	90FD0123	WA State Department Social and Health Services				\$60,000
ACF	OCSE	Section 1115	90FD0124	TX Office of Attorney General				\$60,000
ACF	OCSE	Section 1115	90FD0125	LA Department of Social Services				\$59,983
ACF	OCSE	SIP	90FD0083	Philadelphia, PA Housing Authority				\$50,000
ACF	OCSE	SIP	90FD0084	Christian Community Council, Albany, LA				\$50,000
ACF	OCSE	Section 1115	90FD0117	NE Health and Human Services, CSE		N	LC - Y	\$48,487
ACF	OHS	Head Start Partnerships with Hispanic Serving Institutions of Higher Education	90YP0044	University of Cincinnati				\$249,980
ACF	OPRE	Non-Competitive	90XP0198	National Eligibility Workers Association		Y	N	\$100,000
ACF	OPRE	Non-Competitive	90XP0197	Apollon Theater Foundation		Y	N	\$50,000
ACF Totals =								\$3,837,975

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FY 2007 Non-Competitive Grants

Administration for Healthcare Research and Quality (AHRQ)						
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Health Information Technology and Improving Medication Use	HS016970-01	BRIGHAM AND WOMEN'S HOSPITAL	N	Y
						\$1,000,000
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Tools for Optimizing Prescribing, Monitoring and Education	HS016973-01	UNIVERSITY OF ILLINOIS AT CHICAGO	N	Y
						\$1,000,000
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Center For Education and Research in Therapeutics	HS016946-01	UNIVERSITY OF PENNSYLVANIA	N	Y
						\$999,999
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Hospital Medicine and Economics Centers for Education & Research for Therapeutics	HS016967-01	UNIVERSITY OF CHICAGO	N	Y
						\$999,999
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Duke Cardiovascular CERTs	HS016964-01	DUKE UNIVERSITY	N	Y
						\$999,913
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	HMO Research Network CERT III	HS016955-01	HARVARD PILGRIM HEALTH CARE, INC.	N	Y
						\$999,787
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Pursuing Perfection in Pediatric Therapeutics	HS016957-01	CHILDREN'S HOSPITAL MED CTR (CINCINNATI)	N	Y
						\$995,750
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Arizona Center for Education and Research on Therapeutics	HS017001-01	CRITICAL PATH INSTITUTE	N	Y
						\$990,461

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FY 2007 Non-Competitive Grants

AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Vanderbilt Center for Education/Research on Therapeutics	HS016974-01	VANDERBILT UNIVERSITY	N	Y	\$962,462
AHRQ	CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS (CERTS)(U18)	Deep South Musculoskeletal (DSM) CERTs	HS016956-01	UNIVERSITY OF ALABAMA AT BIRMINGHAM	N	Y	\$958,253
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Evidence Standards for Child Health Promotion	HS016769-01	NEW ENGLAND MEDICAL CENTER HOSPITALS			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	The Eighteenth Annual Health Economics Conference	HS016883-01	ARIZONA STATE UNIVERSITY-TEMPE CAMPUS			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Reducing Harm to Patients from Diagnostic Errors	HS017406-01	UNIVERSITY OF ALABAMA AT BIRMINGHAM			\$50,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Building a National Research Model: the Future of HMO-Based Research Conference	HS016842-01	KAISER FOUNDATION RESEARCH INSTITUTE			\$49,999
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	GRADE - Moving Towards a Consensus on a Consistent Approach to Grading Evidence	HS016880-01	CASE WESTERN RESERVE UNIVERSITY			\$49,886
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Nursing Care in Life, Death and Disaster	HS016894-01	AMERICAN NURSES ASSOCIATION			\$49,855
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Health Services Research Competencies Development & Conferences	HS016960-01	UNIVERSITY OF WASHINGTON			\$49,748
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Harmonizing Data Standards for Primary Care	HS016764-01	AMERICAN ACADEMY OF FAMILY PHYSICIANS			\$49,616

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FY 2007 Non-Competitive Grants

AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	International Meeting on Indigenous Child Health	HS016753-01	AMERICAN ACADEMY OF PEDIATRICS			\$49,500
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Improving Quality and Reducing Disparities: Complementary or Competing Goals	HS016993-01	HARVARD UNIVERSITY			\$48,789
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Improving Performance in Practice (PIP) Conference, Practice Redesign Initiative	HS017340-01	AMERICAN BOARD OF MEDICAL SPECIALTIES			\$48,069
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Enhancing the PBRN Model to Improve the Medication Use Process	HS016844-01	UNIVERSITY OF FLORIDA			\$47,200
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Research Priorities in Ambulatory Management of Obstructive Sleep Apnea Workshop	HS017402-01	UNIVERSITY OF PENNSYLVANIA			\$46,500
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	EBP Leadership Summit: Improving health outcomes for high risk children and teens	HS016758-01	ARIZONA STATE UNIVERSITY-TEMPE CAMPUS			\$46,481
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Collaborative Practice and Research to Improve Functional Outcomes for Amputees	HS016839-01 A1	OLD DOMINION UNIVERSITY			\$45,430
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	National Quality Forum - Annual Policy Conference	HS017401-01	NATIONAL QUALITY FORUM			\$44,509
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Translating Evidence to Quality Care: Getting the Message to Your Constituency	HS017397-01	JOHNS HOPKINS UNIVERSITY			\$43,117
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Global Summit on International Breast Health Implementation	HS017218-01	FRED HUTCHINSON CANCER RESEARCH CENTER			\$40,782
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Health Journalism 2007 - national conference on health care journalism	HS016284-02	CENTER FOR EXCELLENCE IN HEALTH CARE JOURNALISM			\$40,643

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FY 2007 Non-Competitive Grants

AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Measuring Quality - The Impact of Patient Complexity	HS016856-01	SOCIETY OF GENERAL INTERNAL MEDICINE		\$40,000
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Small Grant Program for Conference Support	HS016850-01	AMERICAN INSTITUTES FOR RESEARCH		\$34,665
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	A Conference Grant to Support the 29th Annual Meeting of SMDM	HS017305-01	UNIVERSITY OF PITTSBURGH AT PITTSBURGH		\$32,260
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Eliminating Health Care Disparities in the Southwest	HS016881-01	UNIVERSITY OF TEXAS HLTH SCI CTR SAN ANT		\$29,300
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	Rehabilitation Research & Training Center on Aging with Development Disabilities	HS016992-01	UNIVERSITY OF ILLINOIS AT CHICAGO		\$25,040
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	6th Annual Forum for Improving Children's Healthcare - Purgng Harm From Children	HS016879-01	NATL INITIATIVE/CHILDRENS HLTHCARE QUAL		\$23,200
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	VCU Women's Health Dissemination Conference	HS016840-01	VIRGINIA COMMONWEALTH UNIVERSITY		\$19,098
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	2007 Int'l Meeting on Simulation in Healthcare video taping and distribution	HS016747-01	SOCIETY FOR SIMULATION IN HEALTHCARE		\$19,036
AHRQ	SMALL GRANT PROGRAM FOR CONFERENCE SUPPORT (R13)	2007 Child Health Services Research Meeting	HS016887-01	ACADEMYHEALTH		\$15,000
					AHRQ Total =	\$11,044,347

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FY 2007 Non-Competitive Grants

Administration on Aging (AoA)									
AoA	(Unsolicited)	Aging Strategic Alignment Project for the Aging Network	90AM3142	Benjamin Rose Institute	Y	Y	Y		\$399,915
AoA	(Unsolicited)	Study the effects of OAA services on Medicare utilization and costs	90AM3163	Lieutenant Governor's Office on Aging	Y	Y	Y		\$100,000
AoA	Elder Care Locator	Elder Care Locator	90AM2746	National Association of Area Agencies on Aging					\$812,176
								AoA Total =	\$1,312,091
Office of the Assistant Secretary for Preparedness and Response (ASPR)									
ASPR	Healthcare Facility Partnership Program	National Medical Response Team - National Capital Region's Operations	HPPE070017	Arlington County Fire Department	N	Y			\$202,000
								ASPR Total =	\$202,000

FY 2007 Non-Competitive Grants

Centers for Disease Control and Prevention (CDC)						
CDC	American College Of Sports Medicine's Plan For Physical Activity And Public Hlth	DP001132	American College Of Sports Medicine	N	Y	\$50,000
CDC	CA for Enhancing Public Health Practice Related to Birth Defects and Developmental Disabilities	DD000268	University Of South Carolina At Columbia	N	Y	\$217,501
CDC	Capacity Building Asst. For Global HIV/AIDS Program Development Through Technical Assistance collaboration with the National Association of State and Territorial AIDS Directors	U62PS624596	National Association of State and Territorial AIDS Directors (NASTAD)	N	Y	\$2,663,000
CDC	China-US Collaborative Population-Based Surveillance and Research Program for Maternal-Child and Family Health	U01 DD000293	Peking University Health Science Center	N	Y	\$1,671,000
CDC	Collaborations In Public Health Law As It Relates to Oral Health Issues	DP001085	Columbia University Health Sciences (NY)	N	Y	\$118,942
CDC	Collaborative Public Health Research Program in Denmark	U10 DD000230	Danish Agency/Science, Tech & Innovation	N	Y	\$1,064,032
CDC	Cooperative Agreement to the Medical Research Council (MRC) of South Africa for TB Control and HIV Prevention, Care, and Treatment Activities (U51)	U51 PS000729	South African Medical Research Council	N	Y	\$8,682,786
CDC	Cooperative Agreement with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Through the World Health Organization (WHO) as Bona Fide Agent	U62PS025108	World Health Organization/UNAIDS	N	Y	\$1,000,000

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FY 2007 Non-Competitive Grants

CDC	Cooperative Agreement with the Kenya Medical Research Institute (KEMRI)	KEMRI/CDC Program	U19CB000323	Kenya Medical Research Institute (KEMRI)	N	Y	\$20,422,739
CDC	Developing an Agenda for Laboratory Practice Research based on the 2007 Institute: Managing for Better Health	A Research Agenda for Health Laboratory Practice	U47 CB000556	University of Pittsburgh	N	Y	\$300,000
CDC	Development of Influenza Surveillance network	Development of Influenza Surveillance network	U51CB000394	Ministry of Health	N	Y	\$300,000
CDC	Duchenne and Becker Muscular Dystrophy Education and Outreach	Duchenne and Becker Muscular Dystrophy Education and Outreach Initiative	U38 DD000337	Parent Project Muscular Dystrophy	N	Y	\$706,797
CDC	Enhancing Communicable Disease Surveillance in the African region	Enhancing Communicable Disease Surveillance in the African region	U51CB000421	WHO/AFRO	N	Y	\$100,000
CDC	Environmental Health Academic Programs	Environmental Health Academic Programs	U50CCU024903	Association of Environmental Academic Programs	N	Y	\$180,000
CDC	Environmental Health Education & Monitoring Activities	Environmental Health Education & Monitoring Activities	TS 000063	State of Oklahoma DOH	N	Y	\$160,550
CDC	Expanding and Integrating HIV Care in the Republic of Kenya under the President's Emergency Plan for AIDS Relief	Expanding and Integrating HIV Care in Kenya	U2GPS000644	National AIDS/STI Control Program	N	Y	\$7,460,197
CDC	Expanding Existing Birth Defects Surveillance Programs To Include Data On Stillbirths	Expansion Of Iowa's Birth Defects Registry (Iowa Registry For Congenital & Infant)	DP000734	Iowa Department of Health	N	Y	\$300,000
CDC	Expanding HIV/AIDS Program Activities of the Ministry of Health of the Kingdom of Cambodia under the President's Emergency Plan for AIDS Relief	Expanding HIV/AIDS Program Activities of the Ministry of Health of the Kingdom of Cambodia under the President's Emergency Plan for AIDS Relief	U2G PS001092	National Center for HIV/AIDS, Dermatology & STDs, Cambodia	N	Y	\$600,000
CDC	Expanding the Overseas Health Assessment of US Bound Refugees	Expanding the Overseas Health Assessment of US Bound Refugees	U50 CB000578	International Organization for Migration	N	Y	\$245,500

FY 2007 Non-Competitive Grants

CDC	Expansion of HIV/AIDS/STD Surveillance, Care and Prevention activities in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	Expansion of HIV/AIDS/STD Surveillance, Care and Prevention activities in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	U2GPS000647	Ministry of Health and Child Welfare	N	Y	\$500,000
CDC	Health Data Partner in Environmental Public Health Tracking	Health Data Partner in Environmental Public Health Tracking	U38/EH00237	National Environmental Public Health Tracking Program	N	Y	\$100,000
CDC	Human Resources Capacity Building for Implementation of the Anti-Retroviral Therapy (ART) Program in the Federal Democratic Republic of Ethiopia under the President's Emergency Plan for AIDS Relief	Human Resources Capacity Building for Implementation of the Anti-Retroviral Therapy (ART) Program in the Federal Democratic Republic of Ethiopia under the President's Emergency Plan for AIDS Relief	U2GPS000834-01	Ethiopian Medical Association	N	Y	\$200,000
CDC	Human Resources Capacity Building for Implementation of the Anti-Retroviral Therapy (ART) Program in the Federal Democratic Republic of Ethiopia under the President's Emergency Plan for AIDS Relief	Human Resources Capacity Building for Implementation of the Anti-Retroviral Therapy (ART) Program in the Federal Democratic Republic of Ethiopia under the President's Emergency Plan for AIDS Relief	U2GPS000834	Ethiopian Medical Association	N	Y	\$200,000
CDC	Immunization Information System (IIS) Capacity Building	AIRA IIS Capacity Building Initiative	U38 000160	Medical & Health Research Association of NYC, Inc.	N	Y	\$740,000
CDC	Implementing Public Health Programs & Strengthening Public Health Science in Guatemala	Implementing Public Health Programs & Strengthening Public Health Science in Guatemala & the Central American Region	U51GH000011	Universidad Del Valle Guatemala	N	Y	\$4,262,011
CDC	Improving Laboratory Capacity and Quality for HIV/AIDS Programming in the Kingdom of Cambodia Under the President's Emergency Plan for AIDS Relief	Improving Laboratory Capacity and Quality for HIV/AIDS Programming in the Kingdom of Cambodia Under the President's Emergency Plan for AIDS Relief	U2UG PS000939	National Institute of Public Health, Cambodia	N	Y	\$100,000

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FY 2007 Non-Competitive Grants

CDC	Improving Overseas Health assessment and management of US Bound refugees	Improving Overseas Health assessment and management of US Bound refugees	U51CH000418	International Organization for Migration	N	Y	\$20,500
CDC	Increasing the Capacity of the Ministry of Health to Expand Coordinated HIV Prevention	Increasing the Capacity of the Ministry of Health to Expand Coordinated HIV Prevention, Care, Treatment, & Strategic Information Programs in the United Republic of Tanzania under the President's Emergency Plan for AIDS Relief	U2ZGP000972	Ministry of Health	N	Y	\$3,309,880
CDC	Information Interchange and Technical Assistance for Human Immunodeficiency Virus (HIV) Prevention -- Community-Based HIV Prevention	Information Interchange and Technical and Financial Assistance for Human Immunodeficiency Virus (HIV) Prevention - Community-Based HIV Prevention	5 U62 PS 300609	The US Conference of Mayors Research and Information Fund	N	Y	\$970,200
CDC	National Environmental Public Health Tracking Program	National Environmental Public Health Tracking Program	U38EH00239	National Association of Public Health Statistics & Info Sys	N	Y	\$100,000
CDC	National wide No-Cost Glaucoma Screening Project Using Mobile Units	National wide No-Cost Glaucoma Screening Project Using Mobile Units	DP001134	Friends Of The Cong Glaucoma Caucus Fnd (NY)	N	Y	\$3,285,588
CDC	Oklaoma Acute Stroke Registry Will Develop Quality Improvement Activities With DP	Oklaoma Acute Stroke Registry Will Develop Quality Improvement Activities With DP	DP000856	Oklaoma State Department Of Health	N	Y	\$200,705
CDC	Optima Resources and Care for Children with Craniofacial Malformations	Determination of Optimal Resources & Care For Children With Craniofacial Defects	R01 DD000294	National Foundation For Facial Reconst.	N	Y	\$200,000
CDC	Resident Postdoctoral Research Fellowship Program in Microbiology	Strengthening Coordination & Develop of HIV/AIDS Prev & Care in the Socialist Rep	U2G PS000747	Vietnam Administration HIV/AIDS Control	N	Y	\$8,160,928
CDC	State Vital Statistics Improvement Program	State Vital Records Jurisdictions	U38 SH000001	Natl Assn Pub Hlth Stats & Inform Sys	N	Y	\$609,180
CDC	Strengthening Coordination and Development of HIV/AIDS Prevention and Care in the Socialist Republic of Vietnam under the US President's Emergency Plan for AIDS Relief	Strengthening Coordination and Development of HIV/AIDS Prevention and Care in the Socialist Republic of Vietnam under the US President's Emergency Plan for AIDS Relief	U2G PS000747	Socialist Republic of Vietnam	N	Y	\$8,160,928

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FY 2007 Non-Competitive Grants

CDC	Strengthening Laboratory Infrastructure, Strategic-Information Capacity, and Technical Support for Rapid Scale up of ART in the Federal Democratic Republic of Ethiopia and the President's Emergency Plan for AIDS Relief	U2GFS000825-01	Ethiopian Health and Nutrition Research Institute	N	Y	\$3,886,850
CDC	Strengthening Laboratory Infrastructure, Strategic-Information Capacity, and Technical Support for Rapid Scale up of ART in the Federal Democratic Republic of Ethiopia and the President's Emergency Plan for AIDS Relief	U2GFS000825	Ethiopian Health and Nutrition Research Institute	N	Y	\$3,886,850
CDC	Strengthening the Capacity to Manage national HIV Programs and Improvement of Care and Treatment in the Republic of Zimbabwe Under the President's Emergency Plan for AIDS Relief	U2GFS000658	National AIDS Council	N	Y	\$100,000
CDC	Support for National Prevention Care, Treatment, Laboratory Services, Strategic Information and Policies for HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis in the Republic of Uganda under PEPFAR	U2G FS000936	Ministry of Health	N	Y	\$3,445,196
CDC	Thalassemia Prevention Education And Outreach Program	DD000331	Coley's Anemia Foundation, Inc (NY)	N	Y	\$200,000
CDC	The Christopher Reeve Paralysis Foundation - Christopher and Dana Reeve Paralysis Resource Center (PRC)	U59 DD000338	Christopher Reeve Paralysis Foundation	N	Y	\$4,102,250

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FY 2007 Non-Competitive Grants

CDC	Tourette Syndrome National Education and Outreach Program	Tourette Syndrome National Education and Outreach Program	DD000343	Tourette Syndrome Association, Inc. (NT)	N	Y	\$450,000
CDC	Tourette Syndrome National Education And Outreach Program	Tourette Syndrome National Education And Outreach Program	DD000343	Tourette Syndrome Association, Inc	N	Y	\$450,000
CDC	Building Laboratory Capacity through Pre-service and IN-service Training of Laboratory Technologists in the Republic of Malawi under PEPFAR	Building Laboratory Capacity through Pre-service and IN-service Training of Laboratory Technologists in the Republic of Malawi under PEPFAR	U2G/PS000804	Howard University	N	Y	\$578,100
CDC	Enhancement of HIV Reference Laboratory Program and HIV/AIDS Surveillance Activities in the Republic of Malawi under PEPFAR	Enhancement of HIV Reference Laboratory Program and HIV/AIDS Surveillance Activity	U2G/PS000798	Ministry of Health	N	Y	\$100,000
CDC	Strengthening the Quality and Scope of the Master of Public Health (MPH) Degree in the School of Medicine in the Republic of Zambia under PEPFAR	Strengthening the Quality and Scope of the Master of Public Health (MPH) Degree	U2G/PS000749	University of Zambia School of Medicine	N	Y	\$100,000
CDC	Support for Routine, Confidential Op-out HIV Testing in Settings to Prevent the Transmission of HIV from Mothers to Their Children, and for Developing Systems to Bring HIV-Exposed Infants into Care and Treatment in the Republic of Zambia under PEPFAR	Prevention of Mother to Child Transmission of HIV (PMTCT) & Pediatric HIV Care In	U2G/PS000799	UNICEF Zambia	N	Y	\$75,000
CDC		THE AIDS SUPPORT ORGANIZATION EXPANDED & INTEGRATED HIV TESTING FOR POPULATIONS DISPROPORTIONATELY AFFECTED BY	1 U2G PS000934-01	THE AIDS SUPPORT ORGANIZATION (TASO)			\$7,630,237
CDC			1 U62 PS000786-01	NEW YORK CITY HEALTH/MENTAL HYGIENE			\$5,443,500

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FY 2007 Non-Competitive Grants

CDC	PS07-768, Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing	1 U62 PS000762-01	FLORIDA STATE DEPARTMENT OF HEALTH		\$4,854,571
CDC	DEVELOPMENT OF NEW DIAGNOSTIC METHODS/SURVEILLANCE PROGRAM	1 U51 CK000100-01	CASE WESTERN RESERVE UNIVERSITY		\$3,237,392
CDC	EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING FOR POPULATIONS	1 U62 PS000792-01	MARYLAND STATE DEPT OF HLTH/MTL HYGIENE		\$2,769,496
CDC	EXPANSION OF NATIONAL PEDIATRIC HIV/AIDS PREVENTION, CARE AND TREATMENT AND TRAIN	1 U2G PS000942-01	BAYLOR COLL OF MED CHILDREN'S FDN-UGANDA		\$2,724,604
CDC	THE TSHEPANG TRUST	1 U2G PS000793-01	TSHEPANG TRUST		\$2,324,451
CDC	STRENGTHENING WORKPLACE INTERVENTIONS IN SMME'S IN SOUTH AFRICA	1 U2G PS000811-01	AURUM INSTITUTE FOR HEALTH RESEARCH		\$1,946,300
CDC	PS07-768, Expanded and Integrated HIV Testing for Populations Disproportionately	1 U62 PS000789-01	GEORGIA STATE DEPT OF HUMAN RESOURCES		\$1,922,906
CDC	PS07-768, Expanded and Integrated HIV Testing for Populations Disproportionately	1 U62 PS000769-01	CHICAGO DEPARTMENT OF PUBLIC HEALTH		\$1,904,924
CDC	HIV/AIDS PREVENTION CARE AND TREATMENT ACCESS PROJECT FOR SOUTH AFRICAN TEACHERS	1 U2G PS000797-01	EDUCATION LABOUR RELATIONS COUNCIL		\$1,719,796
CDC	PS07-768, EXPANDED and INTEGRATED HIV TESTING	1 U62 PS000791-01	NC STATE DEPT/HLTH & HUMAN SERVICES		\$1,719,000
CDC	STRENGTHENING WORKPLACE INTERVENTIONS IN SMALL AND MEDIUM ENTERPRISES IN THE	1 U2G PS000794-01	SOUTHERN AFRICAN BUSINESS COALITION		\$1,694,557
CDC	PS07-768, Expanded and Integrated HIV Testing for Populations Disproportionately	1 U62 PS000764-01	NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS		\$1,528,000
CDC	HIV & AIDS PREVENTION AND PALLIATIVE CARE FOR TEACHERS, ORPHANS AND VULNERABLE	1 U2G PS000826-01	SOUTH AFRICAN DEMOCRATIC TEACHERS UNION		\$1,512,912

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FY 2007 Non-Competitive Grants

CDC	EXPANDED AND INTEGRATED HIV TESTING	1 U62 PS000778-01	DISTRICT OF COLUMBIA DEPT OF MENTAL HLTH		\$1,461,874
CDC	EXPANDED HIV TESTING	1 U62 PS000780-01	LOUISIANA STATE OFFICE OF PUBLIC HEALTH		\$1,432,500
CDC	NATIONAL HEMOPHILIA FOUNDATION'S PROPOSAL TO PREVENT SECONDARY CONDITIONS	1 U27 DD000322-01	NATIONAL HEMOPHILIA FOUNDATION		\$1,300,000
CDC	EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING FOR POPULATIONS	1 U62 PS000788-01	CITY OF PHILADELPHIA PUBLIC HEALTH DEPT		\$1,241,500
CDC	EXPANDED AND INTEGRATED HIV TESTING	1 U63 PS000767-01	NEW YORK STATE DEPT OF HEALTH		\$1,050,500
CDC	EXPANDED and INTEGRATED HIV TESTING for POPULATIONS DISPROPORTIONATELY AFFECTED	1 U62 PS000775-01	HOUSTON DEPARTMENT/HEALTH/HUMAN SRVS		\$1,050,500
CDC	EXPANDED HIV TESTING PREVALENCE HEALTH CARE SETTINGS TO ADDRESS RACIAL/ETHNIC DISP	1 U62 PS000771-01	MICHIGAN STATE DEPT OF COMMUNITY HEALTH		\$957,131
CDC	EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING FOR POPULATIONS	1 U62 PS000774-01	SOUTH CAROLINA STATE DEPT OF HLTH/ENV		\$955,000
CDC	PS07-768, Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing	1 U62 PS000763-01	TENNESSEE STATE DEPARTMENT OF HEALTH		\$955,000
CDC	EXPANSION OF ZEHRRP'S COUPLES VOLUNTARY COUNSELING AND TESTING SERVICES	1 U2G PS000758-01	EMORY UNIVERSITY		\$750,000
CDC	EXPANSION OF ZEHRRP'S COUPLES VOLUNTARY COUNSELING AND TESTING SERVICES	7 U2G PS000758-02	ZAMBIA-EMORY HIV RESEARCH PROJECT		\$750,000
CDC	EXPANDED AND INTEGRATED HIV TESTING FOR POPULATIONS DISPROPORTIONATELY AFFECTED B	1 U62 PS000768-01	LOS ANGELES CNTY OFF OF AIDS PROGS & POL		\$715,350

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FY 2007 Non-Competitive Grants

CDC		PS07-768, Expanded and Integrated HIV Testing for Populations Disproportionately	1 U62 PS000787-01	OHIO STATE DEPARTMENT OF HEALTH			\$725,800
CDC		PS07-768, Expanded and Integrated HIV Testing for Populations Disproportionately	1 U62 PS000765-01	CA ST DEPT OF HLTH SRVS--OFFICE OF AIDS			\$716,250
CDC		PS07-768, EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING	1 U62 PS000766-01	VIRGINIA STATE DEPT OF HEALTH			\$706,700
CDC		EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING FOR POPULATIONS	1 U62 PS000770-01	MISSOURI STATE DEPT/ HEALTH & SENIOR SRV			\$690,000
CDC		EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING FOR POPULATIONS	1 U62 PS000772-01	CONNECTICUT STATE DEPT OF PUBLIC HEALTH			\$690,000
CDC		EXPANDED & INTEGRATED HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING FOR POPULATIONS	1 U62 PS000777-01	PENNSYLVANIA STATE UNIV HERSHEY MED CTR			\$690,000
CDC		PS07-768, Expanded and Integrated HIV Testing for Populations Disproportionately	1 U62 PS000776-01	MASSACHUSETTS STATE DEPT OF PUB HEALTH			\$690,000
CDC		STOP THE CLOT EDUCATION PROJECT	1 U27 DD000326-01	NATL ALLIANCE/THROMBOSIS/THR OMBOPHILIA			\$675,000
CDC		ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE.IMP. OF STATE ASTHMA PL	2 U59 EH522472-06	ILLINOIS STATE DEPT OF PUBLIC HEALTH			\$600,000
CDC		ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE.IMP. OF STATE ASTHMA PL	2 U59 EH922471-06	PUBLIC HEALTH INSTITUTE			\$600,000
CDC		ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE.IMP. OF STATE ASTHMA PL	2 U59 EH522470-06	MINNESOTA STATE DEPT OF HEALTH			\$596,979
CDC		None	1 U2G PS000804-01	HOWARD UNIVERSITY			\$578,100

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FY 2007 Non-Competitive Grants

CDC		DEVELOPMENT AND EVALUATION OF EVIDENCE-BASED LAB MEDICINE PERFORMANCE INDICATORS	1 U47 CB000570-01	UNIVERSITY OF PITTSBURGH				\$500,000
CDC		INCREASE ACCESS TO HIV COUNSELING, TESTING IN SOUTH AFRICA	1 U2G PS000812-01	AFRICAN MEDICAL & RESEARCH FOUNDATION				\$500,000
CDC		INCREASE ACCESS TO VOLUNTARY, CONFIDENTIAL HIV SCREENING & DIAGNOSTIC HIV COUNSEL	1 U2G PS000806-01	JHPIEGO				\$500,000
CDC		INCREASE ACCESS TO VOLUNTARY, CONFIDENTIAL HIV SCREENING & DIAGNOSTIC HIV COUNSEL	1 U2G PS000807-01	ACADEMY FOR EDUCATIONAL DEVELOPMENT				\$500,000
CDC		LIFE CHOICES PROGRAM - VOLUNTEER COUNSELING AND TESTING PROJECT	1 U2G PS000810-01	SALESIAN MISSIONS, INC.				\$500,000
CDC		PROJECT ACTS: ENGAGING SOUTH AFRICAN YOUTH IN HIV COUNSELING, TESTING, CARE & PRE	1 U2G PS000808-01	MONTEFIORE MEDICAL CENTER (BRONX, NY)				\$500,000
CDC		Health Leadership Institute	1 U14 WC000100-01	UNIVERSITY OF NORTH CAROLINA CHAPEL HILL				\$499,947
CDC		NONE	1 U2G PS000930-01	UNIVERSITY OF THE WEST INDIES				\$484,106
CDC		Strengthening National Capacity for Surveillance and Containment of Avian and Pan	1 U51 JP000157-01	UGANDA VIRUS RESEARCH INSTITUTE				\$476,300
CDC		PAF/CDC HEMATOLOGIC CANCER EDUCATION AND OUTREACH PARTNERSHIP	1 U58 DP001104-01	PATIENT ADVOCATE FOUNDATION				\$456,297
CDC		STRATEGIES TO PROVIDE INFORMATION & EDU FOR PATIENT, THEIR FAMILY MEMBERS, FRIEND	1 U58 DP001108-01	MULTIPLE MYELOMA RESEARCH FOUNDATION				\$424,847
CDC		National Patient and Professional Education Outreach for Underserved Populations	1 U58 DP001105-01	LEUKEMIA AND LYMPHOMA SOCIETY				\$424,299
CDC		TRAINING AND TECHNICAL ASSISTANCE TO SUPPORT ELIMINATION OF PERINATAL HIV TRANSMI	1 U65 PS000815-01	UNIV OF MEDDET OF N- SCHOOL OF NURSING				\$423,033

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FY 2007 Non-Competitive Grants

CDC	LYMPHOMA EDUCATION AND AWARENESS PROGRAM	1 U58 DP001110-01	LYMPHOMA RESEARCH FOUNDATION		\$420,373
CDC	ELECTRONIC DISSEMINATION OF HEMATOLOGIC CANCER SURVIVORSHIP MATERIALS WITH APPLIC	1 U58 DP001113-01	OREGON HEALTH & SCIENCE UNIVERSITY		\$418,458
CDC	PS07-733 STD PREVENTION PROGRAM NATIONAL COMMUNICATION NETWORK	1 H25 PS000750-01	NATIONAL COALITION OF STD DIRECTORS		\$399,422
CDC	PS07-764 OB/GYN IMPLEMENTING CDC'S REVISED RECOMMENDATIONS FOR HIV	1 U65 PS000813-01	AMERICAN COLLEGE OF OB AND GYN		\$382,656
CDC	SIBLING SURVIVORS EDUCATION AND INFORMATION DISSEMINATION PROGRAMS	1 U58 DP001112-01	SUPERSIBS		\$382,000
CDC	CENTERS FOR LAW AND PUBLIC HEALTH: A COLLABORATIVE AT JOHN HOPKINS AND GEORGETOWN	1 U90 PR000064-01	JOHNS HOPKINS UNIVERSITY		\$375,000
CDC	AMERICAN INDIAN CANCER COLLABORATIVE FOR WOMEN'S HEALTH	1 U57 DP001138-01	NATIVE AMERICAN CANCER INITIATIVES, INC.		\$350,000
CDC	THE KEY TO SURVIVAL UNLOCKING KNOWLEDGE AROUND BREAST & CERVICAL CANCER SCREENING	1 U57 DP001118-01	SEATTLE INDIAN HEALTH BOARD		\$350,000
CDC	ENACTING WELLNESS ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	1 U58 DP001111-01	ED NETWORK/ADVANCE CANCER CLINICAL TRIALS		\$349,357
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U50 EH724182-04	MISSOURI STATE DEPT OF SOCIAL SERVICES		\$335,000
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH123176-04	MASSACHUSETTS STATE DEPT OF PUB HEALTH		\$335,000
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH124179-04	CONNECTICUT STATE DEPT OF PUBLIC HEALTH		\$335,000
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH324208-04	DC DEPARTMENT OF HEALTH		\$335,000
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH324212-04	MARYLAND STATE DEPT OF HEALTH		\$335,000
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH524190-04	WISCONSIN STATE DEPT OF HEALTH		\$335,000

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FY 2007 Non-Competitive Grants

CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE- HEMATOLOGIC CANCERS- STRATEGIES FOR EDUCATION & OUTREACH	2 U59 EH824177-04 1 U58 DP001114-01	COLORADO STATE DEPT/PUB HLTH & ENVIRONMT NATIONAL COALITION/CANCER SURVIVORSHIP			\$335,000 \$332,507
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE- TEXAS NEWBORN SCREENING PERFORMANCE MEASURE PROJECT (TNSMP)	2 U59 EH824176-04 1 U47 CB000573-01	UTAH STATE DEPARTMENT OF HEALTH TEXAS STATE DEPT OF HEALTH SERVICES			\$331,301 \$329,159
CDC	OFF-THE-JOB SAFETY AND HEALTH INITIATIVE	1 U38 HM000220-01 2 U59 EH324180-04	NATIONAL SAFETY COUNCIL WEST VIRGINIA STATE DEPT HLTH/HUMAN RSCS			\$327,663 \$322,691
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	1 U18 PS000704-01 1 U51 IP000155-01	UNIVERSITY OF PENNSYLVANIA NATIONAL INST FOR COMMUNICABLE DISEASES			\$321,293 \$316,628
CDC	PS07-005 Multi-Site Rapid HIV Testing in Urban Community Mental Health Settings South African Preparedness for Rapid Detection of Highly Pathogenic Avian Influenza	1 U38 HM000205-01 2 U59 EH624189-04	UNIVERSITY OF SOUTHERN CALIFORNIA TEXAS STATE DEPT OF HEALTH SERVICES			\$314,742 \$308,338
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH024213-04	IDaho STATE DEPT OF HEALTH AND WELFARE			\$307,563
CDC	EVIDENCE BASED PRACTICES TO COMMUNITIES WITH PUBLIC HEALTH IN COLLABORATION WITH	1 U38 HM000221-01	COMMUNITY COALITIONS HEALTH INSTITUTE			\$305,000
CDC	EVIDENCE-BASED LABORATORY MEDICINE: QUALITY/PERFORMANCE EVALUATION IN CKD	1 U47 CB000574-01	KAISER FOUNDATION RESEARCH INSTITUTE			\$302,268
CDC	INJURY PREVENTION AND CONTROL RESEARCH AND STATE AND COMMUNITY BASED PROGRAMS Preparedness and Response to Avian and Pandemic Influenza in Rwanda	1 U17 CB001238-01 1 U51 IP000158-01	AMERICAN COLLEGE OF EMERGENCY PHYSICIANS TREATMENT RESEARCH AIDS CENTER (TRAC)			\$300,000 \$300,000

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FY 2007 Non-Competitive Grants

CDC		IMPROVING ACCESS AND UPTAKE OF ROUTINE CONFIDENTIAL COUNSELING AND TESTING IN	1 U2G P5000748-01	INTRACELLULAR INC.			\$300,000
CDC		Adapting SHLE for Detained African American Adolescent Females	1 U46 P5000679-01	EMORY UNIVERSITY			\$294,098
CDC		PROMOTING & PROTECTING HEALTHY SURVIVORSHIP FOR TRANSPLANT PATIENTS, FAMILIES & INCREASE THE NUMBER OF HOSPITALS THAT ARE IMPLEMENTING PERINATAL HIV PREVENTION	1 U58 DP001106-01	NATIONAL MARROW DONOR PROGRAM, INC			\$291,862
CDC		Reducing HIV risk among episodic substance-using MSM	1 U65 P5000818-01	HEALTH RESEARCH AND EDUCATIONAL TRUST			\$283,332
CDC		ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	1 U46 P5000684-01	PUBLIC HEALTH FOUNDATION ENTERPRISES NORTH CAROLINA ST			\$279,213
CDC		Public Health Perspective	2 U59 EH424184-04	DEPT/ENVIRON. HLTH, NR			\$274,418
CDC		NBQHS- CDC COOPERATIVE AGREEMENT WITH NATL.ORG TO APPLY EVIDENCE BASED PRACTICE	1 U38 HM000219-01	NATIONAL BUSINESS GROUP ON HEALTH			\$269,993
CDC		A SYSTEMATIC EFFORT TO MAINTAIN MARYLAND'S VIOLENT DEATH REPORTING SYSTEM THROUGH	1 U17 CE001312-01	MARYLAND STATE DEPT OF HLTH/INTL. HYGIENE			\$265,094
CDC		BLOOD BROTHERHOOD PROGRAM: IMPACTING THE HEALTH OF ADULT MEN WITH BLEEDING DISORDERS	1 U27 DD000321-01	HEMOPHILIA FEDERATION OF AMERICA			\$265,000
CDC		ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH124193-04	NH STATE DEPT/HLTH STATISTICS/DATA MGMT			\$264,069
CDC		VIRGINIA VIOLENT DEATH REPORTING SYSTEM	1 U17 CE001315-01	VIRGINIA STATE DEPT OF HEALTH			\$255,295
CDC		REPORTING DNA-BASED GENETIC TEST RESULT APPLICABLE TO HERITABLE CONDITIONS & OR NATIONAL VIOLENT DEATH REPORTING SYSTEM - MASSACHUSETTS	1 U47 CB000600-01	RAND CORPORATION			\$254,541
CDC			1 U17 CE001316-01	MASSACHUSETTS STATE DEPT OF PUBLIC HLTH			\$251,838

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FY 2007 Non-Competitive Grants

CDC	VIRGINIA ASSESSMENT INITIATIVE PROJECT	1 U38 HK000033-01	VIRGINIA STATE DEPT OF HEALTH		\$250,000
CDC	AMERICAN MEDICAL INFORMATICS ASSOCIATION (AMIA): CDC PARTNERSHIP TO ENHANCE HEALTH	1 U01 HK000033-01	AMERICAN MEDICAL INFORMATICS ASSN		\$250,000
CDC	EVALUATING THE IMPLEMENTATION OF THE CDC'S REVISED RECOMMENDATIONS FOR HIV TESTING	1 U65 PS000817-01	UNIVERSITY OF CALIFORNIA SAN FRANCISCO		\$250,000
CDC	HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000854-01	CALIFORNIA ST DEPT OF HLTH SVCS-SACRAMEN		\$250,000
CDC	ILLINOIS WILL IMPROVE ASSESSMENT CAPABILITY THRU A TIMELY, FLEXIBLE, WEB-BASED DATA	1 U38 HK000049-01	UNITED WAY OF ILLINOIS		\$249,967
CDC	ENHANCING COMMUNITY HEALTH ASSESSMENTS IN ARKANSAS	1 U38 HK000044-01	ARKANSAS STATE DEPT OF HEALTH		\$249,934
CDC	NEW HAMPSHIRE ASSESSMENT INITIATIVE	1 U38 HK000036-01	UNIVERSITY OF NEW HAMPSHIRE		\$249,606
CDC	Adapting Project S.A.F.E.: Reducing STD/HIV Risk in Women Prisoners	1 U86 PS000670-01	UNIVERSITY OF NORTH CAROLINA CHAPEL HILL		\$239,151
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH424206-04	GEORGIA STATE DEPT OF HUMAN RESOURCES		\$235,833
CDC	PS07-003, Minority HIV/AIDS Research Initiative	1 U01 PS000707-01	KINGSBOROUGH COMMUNITY COLLEGE		\$233,658
CDC	PS07-003, Minority HIV/AIDS Research Initiative (MAR)	1 U01 PS000677-01	UNIVERSITY OF KENTUCKY		\$231,063
CDC	PS07-003, Minority HIV/AIDS Research Initiative	1 U01 PS000698-01	NEW YORK ACADEMY OF MEDICINE		\$229,223
CDC	Reducing HIV Heterosexual Risk Among African-American Men	1 U86 PS000691-01	SUNY DOWNSTATE MEDICAL CENTER		\$228,620
CDC	SC VIOLENT DEATH REPORTING SYSTEM (SCVDRS)	1 U17 CE001314-01	SOUTH CAROLINA STATE DEPT OF HLTH/ENV		\$227,150
CDC	NATIONAL FOLIC ACID PROGRAM	1 E11 DD0000312-01	SPINA BIFIDA ASSOCIATION		\$225,000
CDC	NUESTRO FUTURO FOLIC ACID PROMOTION PROGRAM	1 E11 DD0000316-01	MIGRANT HEALTH PROMOTION, INC.		\$225,000
CDC	Reducing sexual risk among African American heterosexual men	1 U86 PS000667-01	NEW YORK BLOOD CENTER		\$223,796

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FY 2007 Non-Competitive Grants

CDC	PS07-003, Minority HIV/AIDS Research Initiative (MARII)	1 U01 PS000671-01	UNIVERSITY OF MIAMI SCHOOL OF MEDICINE			\$220,035
CDC	HIV/AIDS Prevention with African American heterosexual men attending college	1 UR6 PS000690-01	UNIVERSITY OF NORTH CAROLINA GREENSBORO			\$313,126
CDC	MAINTAINING COLLECTION OF THE NEW JERSEY VIOLENT DEATH REPORTING SYSTEM	1 U17 CE001317-01	NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS			\$211,411
CDC	OREGON VIOLENT DEATH REPORTING SYSTEM	1 U17 CE001313-01	PUBLIC HEALTH SERVICES SUNY DOWNSTATE MEDICAL CENTER			\$209,679
CDC	PS07-003, Minority HIV/AIDS Research Initiative (MARII)	1 U01 PS000676-01	CALIFORNIA STATE UNIV- DOMINGUEZ HILLS			\$207,084
CDC	PS07-003, Minority HIV/AIDS Research Initiative (MARII)	1 U01 PS000678-01	UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$204,437
CDC	A RESEARCH AGENDA FOR HEALTH LABORATORY PRACTICE	1 U47 CI000566-01	AMERICAN THROMBOSIS & HEMOSTASIS NETWK			\$200,000
CDC	AMERICAN THROMBOSIS AND HEMOSTASIS NETWORK (ATHN); HEMOPHILIA TREATMENT CTR	1 U27 DD000319-01	COOLEY'S ANEMIA FOUNDATION, INC.			\$200,000
CDC	THALASSEMIA PREVENTION EDUCATION AND OUTREACH PROGRAM	1 U27 DD000331-01	NATIONAL HISPANIC COUNCIL ON AGING			\$200,000
CDC	NATIONAL MINORITY IMMUNIZATION PROJECT	1 U21 IP000144-01	NATIONAL ASIAN WOMEN'S HEALTH ORG			\$200,000
CDC	Promoting Prevention for Healthy Communities: The National Asian American Immunitz	1 U21 IP000140-01	MIGRANT CLINICIANS NETWORK, INC.			\$200,000
CDC	SYSTEMS APPROACH TO IMPROVING NATIONAL STATE AND LOCAL ATTENTION TO IMMUNIZATION	1 U21 IP000141-01	MINISTRY OF HEALTH AND PUBLIC HYGIENE			\$200,000
CDC	Epidemiology and laboratory capacity building for surveillance and response to av	1 U51 IP000154-01	TANZANIA MINISTRY OF HEALTH/SOCIAL WLFRE			\$200,000
CDC	Preparedness and Response to Avian and Pandemic Influenza in United Rep of Tanzan	1 U51 IP000156-01	FEDERAL MINISTRY OF HEALTH ETHIOPIA			\$200,000
CDC	Preparedness and Response to Avian and Pandemic Influenza in the Federal Demo Rep	1 U51 IP000159-01				\$200,000

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FY 2007 Non-Competitive Grants

CDC	EXPANDED ACCESS TO VCT IN THREE RURAL DISTRICTS OF ZAMBIA	1 U2G PS000753-01	UNIVERSITY OF ALABAMA AT BIRMINGHAM			\$200,000
CDC	HUMAN RESOURCE CAPACITY BUILDING TO ACCELERATE UPTAKE OF ART IN ETHIOPIA	1 U2G PS000834-01	ETHIOPIAN MEDICAL ASSOCIATION			\$200,000
CDC	PS07-754 REP9-PACKAGING A PROVEN HIV BEHAVIORAL INTERVENTION FOR USE WITH WOMEN	1 H62 PS000784-01	PUBLIC HEALTH SOLUTIONS			\$200,000
CDC	HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000855-01	DENVER HEALTH AND HOSPITAL AUTHORITY			\$200,000
CDC	EVALUATING USE A RAPID TESTING FOR INFLUENZA IN OUTPATIENT MEDICA SETTING	1 U47 C0000581-01	JOINT COMMISSION UNIVERSITY OF MIAMI			\$199,945
CDC	PS07-754, REP 9 (Pig Proven HIV Behavioral Interventions - HIV)	1 H62 PS000781-01	CORAL GABLES COLUMBIA UNIVERSITY HEALTH SCIENCES			\$198,672
CDC	PS07-003, Minority HIV/AIDS Research Initiative (MAIRI)	1 U01 PS000700-01	UNIVERSITY OF SOUTH CAROLINA AT COLUMBIA			\$192,045
CDC	PS07-003 Minority HIV/AIDS Research Initiative (MAIRI)	1 U01 PS000697-01	RESEARCH TRIANGLE INSTITUTE			\$191,902
CDC	Adapting the Women's CoOp for At-Risk Teens	1 U86 PS000665-01	MINNESOTA STATE DEPT OF HEALTH			\$186,078
CDC	STRENGTHENING SURVEILLANCE FOR INFECTIOUS DISEASES AMONG NEWLY-ARRIVED REFUGEES	1 U50 C0000589-01	CALIFORNIA STATE DEPT OF PUBLIC HEALTH			\$175,360
CDC	STRENGTHENING SURVEILLANCE FOR INFECTIOUS DISEASES AMONG NEWLY ARRIVED IMMIGRANTS	1 U50 C0000592-01	MASSACHUSETTS STATE DEPT OF PUB HEALTH			\$175,000
CDC	STRENGTHENING SURVEILLANCE FOR INFECTIOUS DISEASES AMONG NEWLY-ARRIVED IMMIGRANTS	1 U50 C0000588-01	VIRGINIA STATE DEPT OF HEALTH			\$175,000
CDC	ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE	2 U59 EH024181-04	CHILDREN'S HOSPITAL MED CTR OF AKRON			\$166,463
CDC	OUTREACH TO THE AMISH WITH HEMOPHILIA AN EDUCATION PROGRAM TO DECREASE THE AMISH	1 U27 DD000323-01				\$160,000

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FY 2007 Non-Competitive Grants

CDC	COMMUNITY HEALTH ASSESSMENTS AND HEALTH IMPROVEMENT PLANNING	1 U38 HK000031-01	FLORIDA STATE DEPARTMENT OF HEALTH			\$150,000
CDC	PREVENTING PERINATAL TRANSMISSION OF HIV THROUGH THE PROVISION OF TA AND TRAINING	1 U65 PS000819-01	NATL BLACK ALCOHOLISM & ADDICTIONS CNCL			\$150,000
CDC	HIV SCREENING	1 U65 PS000814-01	PUBLIC HEALTH FOUNDATION ENTERPRISES			\$148,264
CDC	MULTNOMAH COUNTY HEALTHY HOMES CAPACITY BUILDING PROJECT	1 U88 EH000260-01	MULTNOMAH COUNTY OF HUMAN SERVICES			\$136,900
CDC	IOWA EPT OF PUBLIC HEALTH'S HEALTHY HOMES INITIATIVE	1 U88 EH000276-01	IOWA STATE DEPT OF PUBLIC HEALTH			\$132,727
CDC	CONDUCT HEALTHY HOMES ACTIVITIES WITH THE MENOMINEE AND ONEIDA TRIBES	1 U88 EH000264-01	WISCONSIN STATE DEPT OF HLTH/FAMILY SVC			\$132,106
CDC	REDUCING HLTH DISPARITIES AND ENVIRONMENTAL FACTORS THAT AFFECT PRE-SCHOOL	1 U88 EH000283-01	CHILDREN'S ENVIRONMENTAL HEALTH NETWORK			\$128,244
CDC	NORTH CAROLINA COMMUNITY HEALTH ASSESSMENT INTEGRATION PROJECT	1 U38 HK000047-01	NC STATE DEPT/HLTH & HUMAN SERVICES			\$125,000
CDC	RHODE ISLAND ASSESSMENT INITIATIVE/DATA DISSEMINATION PROJECT FOCUSES ON DATA DIS	1 U38 HK000051-01	RHODE ISLAND STATE DEPT OF HEALTH			\$125,000
CDC	STRENGTHEN & EXPAND CAPACITY WITHIN NM DEPT OF HEALTH, COUNTRIES, TRIBES & HLTH	1 U38 HK000040-01	NEW MEXICO STATE DEPARTMENT OF HEALTH			\$125,000
CDC	IMPROVING THE DELIVERY & MANAGEMENT OF HIV/AIDS CARE IN MALAWI THROUGH APPROPRIA	1 U2G PS000740-01	BAOBAB HEALTH PARTNERSHIP, INC			\$124,884
CDC	MISSOURI STATE ASSESSMENT INITIATIVE	1 U38 HK000038-01	MISSOURI STATE DEPT/ HEALTH & SENIOR SRV			\$124,876

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FY 2007 Non-Competitive Grants

CDC		OPERATION MOON DUST/MOSQUITO ABATEMENT AND PREVENTION/AIR QUALITY IMPROVEMENT	1 U88 EH000270-01	JEFFERSON COUNTY HEALTH DEPARTMENT			\$124,692
CDC		PREVENTING WATER RELATED DISEASE AMONG ALASKA NATIVES THROUGH ENHANCED EDUCATION	1 U88 EH000282-01	ALASKA NATIVE TRIBAL HEALTH CONSORTIUM			\$121,827
CDC		WAMPANOAG ENVIRONMENTAL LIFE LEARNING (WELL) INITIATIVE	1 U88 EH000277-01	WAMPANOAG TRIBE OF GAY HEAD			\$120,500
CDC		BOSTON SAFE NAIL SALONS PROJECT	1 U88 EH000267-01	BOSTON PUBLIC HEALTH COMMISSION			\$119,910
CDC		COLLABORATIONS IN PUBLIC HEALTH LAW AS IT RELATES TO ORAL HEALTH ISSUES	1 U38 DP001085-01	COLUMBIA UNIVERSITY HEALTH SCIENCES			\$118,942
CDC		INITIATIVE TO MAXIMIZE COLLABORATIVE CAPACITY TO DEFINE NEEDS, MONITOR OUTCOMES	1 U88 EH000261-01	KENT COUNTY HEALTH DEPARTMENT			\$111,456
CDC		PALAU HEALTHY COMMUNITIES INITIATIVE	1 U88 EH000240-01	REPUBLIC OF PALAU MINISTRY OF HEALTH			\$106,297
CDC		IMPLEMENTATION OF A PROGRAM TO ENHANCE QUALITY COLLECTION	1 U2G PS000745-01	UNIVERSITY OF ZAMBIA			\$100,000
CDC		STRENGTHENING THE QUALITY AND SCOPE OF THE MASTER OF PUBLIC HEALTH (MPH) DEGREE	1 U2G PS000749-01	UNIVERSITY OF ZAMBIA			\$100,000
CDC		STRENGTHENING HIV/AIDS ANTI-RETROVIRAL THERAPY (ART) TRAINING & SVCS PROVISION CAP	1 U2G PS000828-01	HARAMAYA UNIVERSITY			\$100,000
CDC		HIV/AIDS POLICY INITIATIVE: BLDG STATE, COUNTY, AND LOCAL PUBLIC HLTH INFRASTRUCT	1 U22 PS000752-01	NATL ASSN OF COUNTY/CITY HLTH OFFICIALS			\$100,000
CDC		UNIVERSITY OF WASHINGTON WEB-BASED HIV TESTING TUTORIALS	1 U2G PS000821-01	UNIVERSITY OF WASHINGTON			\$100,000
CDC		HIV TRAINING THROUGH PREVENTION CENTERS	1 U62 PS000840-01	UNIVERSITY OF ROCHESTER			\$100,000
CDC		HIV TRAINING THROUGH PREVENTION CENTERS	1 U62 PS000841-01	UNIVERSITY OF WASHINGTON			\$100,000

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FY 2007 Non-Competitive Grants

CDC	HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000843-01	PUBLIC HEALTH SOLUTIONS			\$100,000
CDC	HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000850-01	UNIVERSITY OF TEXAS SW MED CTR/DALLAS			\$100,000
CDC	HIV TRAINING THROUGH PREVENTION TRAINING CENTER	1 U62 PS000845-01	MASSACHUSETTS STATE DEPT OF PUBLIC HLTH			\$99,999
CDC	HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000851-01	JOHNS HOPKINS UNIVERSITY			\$99,997
CDC	ATS TIDE Application	1 U17 CE001236-01	AMERICAN TRAUMA SOCIETY			\$70,000
CDC	INJURY PREVENTION AND CONTROL RESEARCH AND STATE AND COMMUNITY BASED PROGRAMS	1 U17 CE001239-01	NATL ASSN OF COUNTY/CITY HLTH OFFICIALS			\$70,000
CDC	Identifying & Disseminating Best Practices by Collaboration of Pub Hlth & the Ems Terrorism Injuries: Information, Dissemination & Exchange (TIDE)	1 U17 CE001232-01	NATIONAL ASSOCIATION OF EMS PHYSICIANS			\$70,000
CDC	Working Collaboratively: The Central Role of Comm & Training in Response to Injury	1 U17 CE001233-01	SOUTHERN NEVADA HEALTH DISTRICT			\$70,000
CDC	NORTHEAST REGIONAL PUBLIC HEALTH LEADERSHIP INSTITUTE	1 U14 WC000191-01	AMERICAN MEDICAL ASSOCIATION			\$70,000
CDC	SOUTHEAST PUBLIC HEALTH LEADERSHIP INSTITUTE (SEPHLI)	1 U14 WC000118-01	STATE UNIVERSITY OF NEW YORK AT ALBANY			\$60,750
CDC	DEVELOPMENT OF A CALIFORNIA/HAWAII REGIONAL PUBLIC HEALTH LEADERSHIP INSTITUTE	1 U14 WC000104-01	UNIVERSITY OF NORTH CAROLINA CHAPEL HILL			\$60,750
CDC	NETWORK OF REGIONALLY BASED LEADERSHIP INSTITUTE: HEARTLAND KANSAS, MISSOURI AND		PUBLIC HEALTH INSTITUTE			\$57,000
CDC	NORTHWEST PUBLIC HEALTH LEADERSHIP INSTITUTE	1 U14 WC000109-01	SAINT LOUIS UNIVERSITY			\$57,000
CDC		1 U14 WC000106-01	UNIVERSITY OF WASHINGTON			\$57,000

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FY 2007 Non-Competitive Grants

CDC		THE BUCKEYE BLUEGRASS REGIONAL LEADERSHIP ACADEMY	1 U14 WC000108-01	OHIO STATE UNIVERSITY			\$57,000
CDC		GREAT PLAINS PUBLIC HEALTH LEADERSHIP INSTITUTE - REGIONAL PHLI	1 U14 WC000120-01	UNIVERSITY OF NEBRASKA MEDICAL CENTER			\$54,491
CDC		NORTH CENTRAL PUBLIC HEALTH LEADERSHIP INSTITUTE	1 U14 WC000107-01	UNIVERSITY OF MINNESOTA TWIN CITIES			\$52,209
CDC		MID-AMERICA REGIONAL PUBLIC HEALTH LEADERSHIP INSTITUTE (MARPHI)	1 U14 WC000105-01	UNIVERSITY OF ILLINOIS AT CHICAGO			\$51,167
CDC		Program Provides Leadership Skills & Public Health Principles Training to Public Health Professionals	1 U14 WC000115-01	JOHNS HOPKINS UNIVERSITY			\$50,500
CDC		RIHEL: PUBLIC HEALTH LEADERSHIP DEVELOPMENT IN THE ROCKY MOUNTAIN REGION	1 U14 WC000113-01	COLORADO FOUNDATION/PUB HLTH & ENVIROMNTL			\$50,500
CDC		SOUTH CENTRAL PUBLIC HEALTH LEADERSHIP INSTITUTE	1 U14 WC000103-01	TULANE UNIVERSITY OF LOUISIANA			\$50,500
CDC		HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000846-01	NEW YORK STATE DEPT OF HEALTH			\$50,000
CDC		HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000849-01	TEXAS STATE DEPARTMENT OF HEALTH SRVS			\$50,000
CDC		GREAT BASIN PUBLIC HEALTH LEADERSHIP INSTITUTE ADVANCED LEADERSHIP TRAINING PROG	1 U14 WC000111-01	HEALTHINSIGHT			\$50,000
CDC		HIV TRAINING THROUGH PREVENTION TRAINING CENTERS	1 U62 PS000842-01	COLORADO STATE DEPT/PUB HLTH & ENVIROMNT			\$49,591
CDC		SOUTHWEST PUBLIC HEALTH LEADERSHIP INSTITUTE BORDER HEALTH LEADERSHIP PROGRAM	1 U14 WC000104-01	UNIVERSITY OF ARIZONA			\$47,375
CDC		REDUCING HEALTH RISK EXPOSURES FROM FLOODING IN MUNCIE INDIANA	1 U88 EH000271-01	CITY OF MUNCIE			\$40,000
CDC Total =							\$192,653,733

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FY 2007 Non-Competitive Grants

Centers for Medicare and Medicaid Services (CMS)						
CMS	DRA/Hurricane Katrina Related Grants	Provider Stabilization Grant	1MOCMS300157	LA State Dept. of Health and Hospitals	N	Y
CMS	DRA/Hurricane Katrina Related Grants	Provider Stabilization Grant	1MOCMS300159	MS Office of the Governor/Medicaid Div.	N	Y
CMS	DRA/Hurricane Katrina Related Grants	Provider Stabilization Grant	1MOCMS300158	AL State Medicaid Agency	N	Y
CMS	DRA/Hurricane Katrina Related Grants	Primary Care Access Stabilization Grant	1MOCMS300175	LA State Dept. of Health and Hospitals	N	Y
CMS	DRA/Hurricane Katrina Related Grants	Professional Workforce Supply Grant	1MOCMS300160	LA State Dept. of Health and Hospitals	N	Y
CMS Total =						\$370,000,000

FY 2007 Non-Competitive Grants

Food and Drug Administration (FDA)									
FDA	Food and Drug Administration Research	NATIONAL CENTER FOR FOOD SAFETY AND TECHNOLOGY	U01FD000431-20	ILLINOIS INSTITUTE OF TECHNOLOGY	N	Y			\$5,000,000
FDA	Food and Drug Administration Research	COOPERATIVE AGREEMENT TO SUPPORT JIFSAN	U01FD001418-11	UNIVERSITY OF MARYLAND	N	Y			\$2,000,000
FDA	Food and Drug Administration Research	SCIENCE BASED AUTHENTICATION OF DIETARY SUPPLEMENTS	U01FD002071-07	UNIVERSITY OF MISSISSIPPI	N	Y			\$1,610,000
FDA	Food and Drug Administration Research	COLLABORATIVE CARDIOVASCULAR DRUG SAFETY AND BIOMARKER RESEARCH PROGRAM	U01FD003379-02	Critical Path Institute	N	Y			\$705,486
FDA	Food and Drug Administration Research	ASSURING RADIATION PROTECTION	U01FD000005-26	CONFERENCE OF RADIATION PROGRAM DIRECTORS, INC	N	Y			\$395,000
FDA	Food and Drug Administration Research	PHASE I/II STUDIES OF EGEN-001 THERAPY FOR OVARIAN CANCER	R01FD003374-01	Expression Genetics, Inc.	N	Y			\$350,000
FDA	Food and Drug Administration Research	SHELLFISH SAFETY ASSISTANCE PROJECT	U01FD000891-15	INTERSTATE SHELLFISH SANITATION CONFERENCE	N	Y			\$325,000
FDA	Food and Drug Administration Research	INTERNATIONAL PROGRAMME ON CHEMICAL SAFETY	U01FD000009-26	WORLD HEALTH ORGANIZATION	N	Y			\$120,000
FDA	Food and Drug Administration Research	IMPROVING THE SAFETY OF FRESH FRUITS AND VEGETABLES	U01FD001941-08	NEW MEXICO STATE UNIVERSITY	N	Y			\$106,002
FDA	Food and Drug Administration Research	PROYECTO INFORMAR FDA HISPANIC OUTREACH INITIATIVE	U01FD002260-03	NATIONAL ALLIANCE FOR HISPANIC HEALTH (THE)	N	Y			\$35,000
FDA	Food and Drug Administration Research	AFDO 2007 ANNUAL EDUCATIONAL CONFERENCE	R13FD003471	ASSOCIATION OF FOOD & DRUG OFFICIALS					\$25,000
FDA	Food and Drug Administration Research	INTERSTATE SHELLFISH SANITATION CONFERENCE BIENNIAL MEETING	R13FD003472	INTERSTATE SHELLFISH SANITATION CONFERENCE					\$25,000
FDA	Food and Drug Administration Research	2007 NATIONAL CONFERENCE ON INTERSTATE MILK SHIPMENTS	R13FD003424	NATIONAL CONFERENCE ON INTERSTATE MILK SHIPMENTS					\$25,000
FDA	Food and Drug Administration Research	NAT. ENVIRONMENTAL HEALTH ASSOC. (NEHA) 71 ANNUAL EDUCATIONAL CONF & EXHIBITION	R13FD003474	NATIONAL ENVIRONMENTAL HEALTH ASSOCIATION					\$25,000

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FDA	Food and Drug Administration_Research	NATIONAL EGG REGULATORY OFFICIALS 15TH ANNUAL CONFERENCE & TRAINING SEMINAR	R13FD003433	NATL EGG REGULATORY OFFICIALS			\$25,000
FDA	Food and Drug Administration_Research	COLORADO HIV/AIDS TREATMENT	R18FD002648-03	JUST RESEARCH & TRAINING INSTITUTE, INC	N	Y	\$15,000
FDA	Food and Drug Administration_Research	HEALTH FRAUD TASK FORCE	R18FD002647-03	NATIONAL ASSOCIATION OF SOCIAL WORKERS, INDIANA CHAPTER	N	Y	\$15,000
FDA	Food and Drug Administration_Research	STATE FOOD SAFETY TASK FORCE	R13FD003068-02	DE ST DEPARTMENT OF HEALTH & SOCIAL SERVICES	N	Y	\$5,000
FDA	Food and Drug Administration_Research	FOOD SAFETY TASK FORCE CONFERENCE	R13FD003637-04	IA ST DEPARTMENT OF INSPECTION & APPEALS	N	Y	\$5,000
FDA	Food and Drug Administration_Research	MICHIGAN FOOD SAFETY TASK FORCE MEETINGS	R13FD003066-03	MI ST DEPARTMENT OF AGRICULTURE	N	Y	\$5,000
FDA	Food and Drug Administration_Research	FOOD SAFETY TASK FORCE SMALL CONFERENCE GRANTS	R13FD002630-04	MN DEPT OF AGRIC.	N	Y	\$5,000
FDA	Food and Drug Administration_Research	FOOD SAFETY TASK FORCE CONFERENCE	R13FD002622-04	MO ST DEPARTMENT OF HEALTH & SENIOR SERVICES	N	Y	\$5,000
FDA	Food and Drug Administration_Research	FOOD SAFETY TASK FORCE CONFERENCE	R13FD002639-04	NC ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$5,000
FDA	Food and Drug Administration_Research	STATE FOOD SAFETY AND FOOD SECURITY TASK FORCE MEETINGS	R13FD003188-03	NI ST DEPARTMENT OF HEALTH AND SENIOR SERVICES	N	Y	\$5,000
FDA	Food and Drug Administration_Research	NEVADA FOOD SAFETY TASK FORCE	R13FD002638-04	NV ST DAIRY COMMISSION	N	Y	\$5,000
FDA	Food and Drug Administration_Research	PA ACT 315 MEMBERS MEETING	R13FD003191-03	PA ST DEPARTMENT OF AGRICULTURE	N	Y	\$5,000
FDA	Food and Drug Administration_Research	TEXAS FOOD SAFETY AND DEFENSE TASK FORCE	R13FD003468-01	TX DEPT OF STATE HEALTH SERVICES	N	Y	\$5,000
FDA	Food and Drug Administration_Research	WASHINGTON STATE DEPARTMENT OF AGRICULTURE FOOD SAFETY AND DEFENSE COUNCIL MEETIN	R13FD003344-02	WA ST DEPARTMENT OF AGRICULTURE	N	Y	\$5,000
FDA	Food and Drug Administration_Research	WEST VIRGINIA FOOD SAFETY AND FOOD SECURITY TASK FORCE *	R13FD003181-03	WV ST DEPARTMENT OF HEALTH AND HUMAN RESOURCES	N	Y	\$5,000

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FDA	Food Safety and Security Monitoring Project	U18FD003139-03	FOOD SAFETY AND SECURITY MONITORING PROJECT FOR THE STA*	AZ ST DEPARTMENT OF HEALTH SERVICES	N	Y	\$421,380
FDA	Food Safety and Security Monitoring Project	U18FD003146-03	FOOD SAFETY AND SECURITY MONITORING OF FERN SAMPLES US*	FL ST DEPARTMENT OF AGRICULTURE & CONSER	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	U18FD003150-03	MN FOOD SAFETY & SECURITY MONITORING PROJECT	MN DEPT OF AGRIC.	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	U18FD003148-03	VA FOOD SAFETY AND SECURITY MONITORING PROJECT	VA ST DEPT OF GENERAL SERVICES	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	U18FD003177-03	SCREENING & IDENTIFICATION OF TOXIC SUBSTANCES IN FOOD *	UNIVERSITY OF CALIFORNIA	N	Y	\$337,210
FDA	Food Safety and Security Monitoring Project	U18FD003164-03	NEW HAMPSHIRE FOOD SAFETY	NH ST DEPARTMENT OF HEALTH & HUMAN SERVICES	N	Y	\$293,282
FDA	Food Safety and Security Monitoring Project	U18FD003170-03	FOOD SAFETY IN THE HEARTLAND (IOWA)	UNIVERSITY OF IOWA	N	Y	\$278,846
FDA	Food Safety and Security Monitoring Project	U18FD003157-03	EXPANDING THE IMPACT OF FERN AT CT AGRICULTURAL EXPERIM*	THE CONNECTICUT AGRICULTURAL EXPERIMENT STATION	N	Y	\$275,211
FDA	Food Safety and Security Monitoring Project	U18FD003485-01	FOOD SAFETY AND SECURITY MONITORING PROJECT	HEALTH RESEARCH, INC - ALBANY DIVISION	N	Y	\$250,000
FDA	Food Safety and Security Monitoring Project	U18FD003492-01	FOOD SAFETY AND SECURITY MONITORING PROJECT	TX DEPT OF STATE HEALTH SERVICES	N	Y	\$350,000
FDA	Food Safety and Security Monitoring Project	U18FD003494-01	FOOD SAFETY AND SECURITY MONITORING PROJECT	UNIVERSITY OF WISCONSIN SYSTEM/BOARD OF REGENTS	N	Y	\$250,000
FDA	Food Safety and Security Monitoring Project	U18FD003388-02	RADIOLOGICAL TESTING OF FOOD SAMPLES	WA ST DEPARTMENT OF HEALTH	N	Y	\$244,622
FDA	Health Promotion/Disease Prevention Program for American Indians and Alaska Natives	U18FD003389-02	MARYLAND FERN SAFETY AND SECURITY MONITORING AND SURGE CAPACITY PROGRAM	MARYLAND STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE	N	Y	\$177,951
FDA	Ruminant Feed Ban Support Project	U18FD003217-03	MICHIGAN RUMINANT FEED BAN SUPPORT PROJECT	MI ST DEPARTMENT OF AGRICULTURE	N	Y	\$275,925
FDA	Ruminant Feed Ban Support Project	U18FD003214-03	NEBRASKA RUMINANT FEED BAN SUPPORT PROJECT	NE ST DEPARTMENT OF AGRICULTURE	N	Y	\$250,000

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FDA	Ruminant Feed Ban Support Project	OFFICE OF THE TEXAS STATE CHEMIST BSE PREVENTION PROGRAM	U18FD003215-03	TEXAS AGRICULTURAL EXPERIMENTAL STATION	N	Y	\$249,852
FDA	Ruminant Feed Ban Support Project	FLORIDA RUMINANT FEED BAN SUPPORT ENHANCEMENT PROJECT	U18FD003225-03	FL ST DEPARTMENT OF AGRICULTURE & CONS SER	N	Y	\$239,888
FDA	Ruminant Feed Ban Support Project	MINNESOTA ANIMAL FEED & BOVINE SPONGIFORM ENCEPHALOPATHY	U18FD003213-03	MN DEPT OF AGRIC.	N	Y	\$234,654
FDA	Ruminant Feed Ban Support Project	ILLINOIS RUMINANT FEED BAN SUPPORT PROJECT	U18FD003222-03	IL DEPT OF AGRICULTURE	N	Y	\$233,528
FDA	Ruminant Feed Ban Support Project	KANSAS BSE INSPECTION PROGRAM	U18FD003223-03	KANSAS DEPT. OF AGRICULTURE	N	Y	\$143,966
FDA	Ruminant Feed Ban Support Project	WISCONSIN EXPANSION OF DATCPS BSE SURVEILLANCE & COMP*	U18FD003211-03	WISCONSIN DEPARTMENT OF AGRICULTURE	N	Y	\$132,230
FDA	State Health Fraud Task Force Grants	STATE FRAUD TASK FORCE GRANTS	R18FD003387-02	TN Office of Inspector General	N	Y	\$15,000
FDA	State Health Fraud Task Force Grants	NEW YORK STATE HEALTH FRAUD TASK FORCE	R18FD002658-03	KINGS COUNTY HOSPITAL CENTER	N	Y	\$15,000
FDA Total =							\$16,480,053

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Health Resources and Services Administration (HRSA)				
HRSA	Technical Assistance to Community and Migrant Health Centers and Homeless	1 U30CS08835-01-00 National Network for Oral Health Access	Yes	\$200,000
HRSA Total =				\$200,000

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Indian Health Services (IHS)						
IHS	INDIANS INTO MEDICINE	INDIANS INTO MEDICINE	D919400180	UNIV OF ARIZONA	N	Y-LC
IHS	INDIANS INTO PSYCHOLOGY	INDIANS INTO PSYCHOLOGY	D94HIS00176	OK STATE UNIV	N	Y-LC
IHS	INDIANS INTO PSYCHOLOGY	INDIANS INTO PSYCHOLOGY	D919400144	UNIV OF MONTANA	N	Y-LC
IHS	INDIANS INTO PSYCHOLOGY	INDIANS INTO PSYCHOLOGY	D919400018	UNIV OF N DAKOTA	N	Y-LC
IHS	NATIONAL COUNCIL OF URBAN INDIAN HEALTH BOARD	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400012	NATIONAL COUNCIL OF URBAN INDIAN HEALTH	N	Y-SS
IHS	NATIONAL INDIAN HEALTH BOARD	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400013	NATIONAL INDIAN HEALTH BOARD	N	Y-SS
IHS	NATIONAL NATIVE AMERICAN EMS ASSOCIATION	DEMONSTRATION PROJECTS FOR INDIAN HEALTH	U259400011	NATIONAL NATIVE AMERICAN EMS ASS	N	Y-SS
IHS	HEALTH PROMOTION DISEASE PREVENTION	CHRONIC CARE	A98HIS300155	INSTITUTE FOR HEALTHCARE IMPROVEMENT	N	Y-SS
IHS	MENTAL HEALTH	COMMUNITY SAFETY INITIATIVE	H75HIS300149	CENTRAL OKLAHOMA	N	Y-LC
IHS	MENTAL HEALTH	COMMUNITY SAFETY INITIATIVE	H75HIS300147	LOWER ELWHA KLALLAM TRIBE	N	Y-LC
IHS	MENTAL HEALTH	COMMUNITY SAFETY INITIATIVE	H75HIS300148	NOOKSACK INDIAN TRIBE	N	Y-LC
IHS	TRIBAL SELF GOVERNANCE	TRIBAL SELF GOVERNANCE PLANNING	U15HIS300152	GRAND PORTAGE	N	Y-LC
IHS	TRIBAL SELF GOVERNANCE	TRIBAL SELF GOVERNANCE PLANNING	U15HIS300151	SANTO DOMINGO	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DHIS300134	INTER TRIBAL COUNCIL OF ARIZONA	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DHIS300095	CONFEDERATED SALISH & KOOTENAI	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DHIS300094	CALIFORNIA RURAL INDIAN HEALTH BOARD	N	Y-LC
IHS	DENTAL	CLINICAL PREVENTION SERVICES	U3DHIS300093	ABERDEEN AREA TRIAL CHAIRMEN'S HEALTH BOARD	N	Y-LC
IHS	NATIVE AMERICAN RESEARCH	CLINICAL PREVENTION SERVICES	U269400019	NATIONAL ASSOC. OF COMM HEALTH REP	N	Y-SS
IHS	NURSING	NURSING PROGRAM	D91HIS300146	SAN DIEGO AMERICAN INDIAN HEALTH	N	Y-LC

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IHS	NURSING	NURSING PROGRAM	D91IHS300145	LAKE COUNTY TRIBAL HEALTH CONSORTIUM FIRST NATIONS COMMUNITY HEALTHSOURCE	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300144		N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300143	SOUTHEAST ALASKA REGIONAL	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300142	UNITED AMERICAN INDIAN INVOLVEMENT	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300140	NATIVE AMERICAN COMMUNITY HEALTH	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300138	LEECH LAKE RESERVATION	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300137	INDIAN HEALTH COUNCIL	N	Y-LC	\$100,000
IHS	NURSING	NURSING PROGRAM	D91IHS300141	CHEROKEE NATION OF OKLAHOMA	N	Y-LC	\$99,929
IHS	NURSING	NURSING PROGRAM	D91IHS300136	HURON POTAWATOMI, INC	N	Y-LC	\$99,819
IHS	NURSING	NURSING PROGRAM	D91IHS300139	CHIPPEWA CREE TRIBE	N	Y-LC	\$99,706
IHS	TRIBAL MANAGEMENT	DEVELOPMENT GRANTS FOR IHS	D23IHS300111	ALASKA STATE TROOPERS	N	Y-SS	\$1,970,450
IHS	TRIBAL SELF GOVERNANCE	TRIBAL SELF-GOVERNANCE NEGOTIATION	U13IHS300083	SAC & FOX OF MISSISSIPPI	N	Y-LC	\$50,000
IHS	TRIBAL SELF GOVERNANCE	TRIBAL SELF-GOVERNANCE NEGOTIATION	U16IHS300082	PAWNEE TRIBE OF OKLAHOMA	N	Y-LC	\$20,000
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400507	NAVAJO AREA IHS	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400480	RIVERSIDE-SAN BERNADINO	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400537	TOHONO OODHAM NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400518	IHS WHITERIVER SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400536	YAKAMA INDIAN HEALTH	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400445	ALBUQUERQUE SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400492	CHOCTAW NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400517	IHS UNITAH & OURAY SU	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	H1D9400458	LEECH LAKE BAND	N	Y-LC	\$397,100

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IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400467	BLACKFEET	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400500	MUSCOGEE CREEK NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400491	CHICKASAW NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400512	COLORADO RIVER	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400495	HASKELL HEALTHCTR	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400486	MISSISSIPPI BAND OF CHOCTAW	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400484	UNITED INDIAN HEALTH SERVICE	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400444	SOUTHEAST REGIONAL HEALTH CONSORTIUM	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400442	SOUTHCENTRAL FOUNDATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400534	WARM SPRINGS HEALTH	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400449	PUEBLO OF ZUNI	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400498	LAWTON INDIAN PHS	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400527	COW CREEK BAND	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400541	PINE RIDGE IHS HOSPITAL	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400494	CHEROKEE NATION	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400510	TUBA CITY REGIONAL	N	Y-LC	\$397,100
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400531	NW WASHINGTON IHB	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400450	RAMAH NAVAJO SCHOOL	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400446	SANTO DOMINGO	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400466	SAULT STE MARIE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400482	TOYABE INDIAN HEALTH	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400540	YUKON-KUSKOKWIM	N	Y-LC	\$324,300

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IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400438	WAGNER HEALTH CARE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400451	TAOS-PICURIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400489	ABSENTEE-SHAWNEE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400453	BAD RIVER BANDS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400468	CONFEDERATED SALISH & KOOTENAI	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400516	HUALAPAI TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400496	INDIAN HEALTH CARE RESOURCE CENTER OF TULSA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400443	MILL LACS BAND	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400533	SEATTLE INDIAN HEALTH BOARD	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400470	FORT BLKNAP INDIAN COMMUNITY	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400478	INDIAN HEALTH COUNCIL	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400479	REDDING RACHERIA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	CARDIOVASCULAR RISK REDUCTION	HID9400487	ST REGIS MOHAWK TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400523	BENEWAH MEDICAL CTR	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400431	CHEYENNE RIVER SIOUX	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400525	CONFEDERATED TRIBE OF CHEHALIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400524	COLVILLE CONFEDERATED TRIBES	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400542	FOND DU LAC RESERVATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400477	INDIAN HEALTH CENTER OF SANTA CLARA	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400459	MEMONINEE INDIAN TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	HID9400539	NORTON SOUND HEALTH CORP	N	Y-LC	\$324,300

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IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400473	ROCKY BOY HEALTH BOARD	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400448	PUEBLO OF SAN FELIPE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400532	QUINIAULT INDIAN NATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400439	WINNEBAGO TRIBE OF NE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400483	UNITED AMERICAN INVOLVEMENT INDIAN	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400435	TRENTON INDIAN SERVICE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400481	SONOMA COUNTY	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400547	SENECA NATION	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400538	KENAITZE INDIAN TRIBE	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400436	RAPID CITY INDIAN HEALTH	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400455	INDIAN HEALTH BOARD OF MINNEAPOLIS	N	Y-LC	\$324,300
IHS	SPECIAL DIABETES PROGRAM FOR INDIANS	DIABETES PRIMARY PREVENTION	H1D9400454	HO CHUNK	N	Y-LC	\$324,300
IHS Total =							\$30,122,288

FY 2007 Non-Competitive Grants

National Institutes of Health (NIH)					
NIH	CONFERENCE GRANTS	25TH ANNUAL SYMPOSIUM ON NONHUMAN PRIMATE MODELS FOR AIDS	R13RR024096-01	MILLER CHRISTOPHER J - UNIVERSITY OF CALIFORNIA DAVIS	\$73,089
NIH	CONFERENCE GRANTS	SOCIETY FOR RESEARCH ON NICOTINE AND TOBACCO ANNUAL MEETING	R13DA016409-06	ESSENBERG THOMAS EVAN - SOCIETY FOR RESEARCH ON NICOTINE/TOBACCO	\$72,475
NIH	CONFERENCE GRANTS	SYMPOSIUM ON NEUROIMAGING IN ALCOHOLISM	R13AA017053-01	KRYSTAL JOHN H - YALE UNIVERSITY	\$62,667
NIH	CONFERENCE GRANTS	TUBEROUS SCLEROSIS COMPLEX CONFERENCE: FROM GENES TO NEW THERAPEUTICS	U13NS060554-01	WHITTEMORE VICKY HOLETS TUBEROUS SCLEROSIS ALLIANCE	\$60,000
NIH	CONFERENCE GRANTS	CLINICAL RESEARCH FOR RARE DISEASES: OPPORTUNITIES, CHALLENGES, AND SOLUTIONS	R13RR024337-01	MERKEL PETER A - BOSTON UNIVERSITY MEDICAL CAMPUS	\$50,000
NIH	CONFERENCE GRANTS	SHARED NEUROBIOLOGY OF AUTISM AND RELATED DISORDERS	U13NS059269-01	MOLDIN STEVEN OWEN - UNIVERSITY OF SOUTHERN CALIFORNIA	\$48,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON OUTCOMES MEASUREMENT	R13DA020332-01A1	CONRAD KENDON J - UNIVERSITY OF ILLINOIS AT CHICAGO	\$45,000
NIH	CONFERENCE GRANTS	2007 CAG TRIPLET REPEAT DISORDERS GORDON CONFERENCE	R13NS058219-01	MERRY DIANE E - GORDON RESEARCH CONFERENCES	\$45,000
NIH	CONFERENCE GRANTS	2007 NEUROFIBROMATOSIS CONFERENCE	R13NS060582-01	CICHOWSKI KAREN M - CHILDREN'S TUMOR FOUNDATION	\$41,800
NIH	CONFERENCE GRANTS	VETERINARIANS IN BIOMEDICAL RESEARCH: BUILDING CAPACITY	R13RR024097-01	ATCHISON MICHAEL L - UNIVERSITY OF PENNSYLVANIA	\$40,500
NIH	CONFERENCE GRANTS	17TH ISSTR MEETING	R13AB076550-01	HANDSFIELD HUGH HUNTER - AMERICAN SOCIAL HEALTH ASSOCIATION	\$40,000
NIH	CONFERENCE GRANTS	38TH ANNUAL INTERNATIONAL NARCOTICS RESEARCH CONFERENCE	R13DA023871-01	BIDLACK JEAN M - INTERNL NARCOTICS RESEARCH CONF INC.	\$40,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SOCIETY OF ADDICTION MEDICINE CONFERENCE	R13DA022952-01	BUNT GREGORY - DAYTOP VILLAGE	\$40,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	AMIA SPRING CONGRESS 2007 INFORMATICS ACROSS THE SPECTRUM FROM CLINICAL CARE TO	R13R024600-01	DETHMER DON EUGENE - AMERICAN MEDICAL INFORMATICS ASSN			\$35,000
NIH	CONFERENCE GRANTS	13TH-17TH CONFERENCES: DRUG ABUSE, IMMUNE MODULATION AND AIDS	R13DA023184-04	CABRAL GUY A. - SOCIETY ON NEUROMIMINE PHARMACOLOGY			\$35,000
NIH	CONFERENCE GRANTS	11TH INTERNATIONAL MYASTHENIA GRAVIS MEETING	R13NS058218-01	BAROHN RICHARD J. - NEW YORK ACADEMY OF SCIENCES			\$35,000
NIH	CONFERENCE GRANTS	3RD INTERNATIONAL FRIEDREICH'S ATAXIA SCIENTIFIC CONFERENCE	R13NS057996-01	WILSON ROBERT B. - FRIEDREICH'S ATAXIA RESEARCH ALLIANCE			\$35,000
NIH	CONFERENCE GRANTS	IMPULSE CONTROL DISORDERS IN PARKINSON'S DISEASE CONFERENCE	U13NS059293-01	STACY MARK A. - DUKE UNIVERSITY			\$35,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONFERENCE ON THE NON-DYSTROPHIC MYOTONIAS	R13NS057995-01	BAROHN RICHARD J. - UNIVERSITY OF KANSAS MEDICAL CENTER			\$35,000
NIH	CONFERENCE GRANTS	11TH INTERNATIONAL CONGRESS ON NEURONAL CEROID LIPOFUSCINOSIS	R13NS059295-01	PEARCE DAVID A. - UNIVERSITY OF ROCHESTER			\$34,200
NIH	CONFERENCE GRANTS	115TH, 116TH AND 117TH CONVENTION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION	R13AA017107-01	BUCKMAN JENNIFER F. - RUTGERS THE ST UNIV OF NJ NEW BRUNSWICK			\$33,163
NIH	CONFERENCE GRANTS	MEDICAL MANAGEMENT OF PEDIATRIC NEUROTRANSITTER DISORDERS- A MULTIDISCIPLINARY	R13NS060363-01	GIBSON K MICHAEL - CHILDREN'S HOSP PITTSBURGH/UPMC HLTH SYS			\$33,000
NIH	CONFERENCE GRANTS	10TH INTERNATIONAL KSHV AND RELATED AGENTS WORKSHOP	R13CA128447-01	WONG SCOTT W. - OREGON HEALTH & SCIENCE UNIVERSITY			\$30,000
NIH	CONFERENCE GRANTS	2007 MOLECULAR BIOLOGY OF HEPATITIS B VIRUSES MEETING	R13AI075934-01	MASON WILLIAM - HEPATITIS B FOUNDATION			\$30,000
NIH	CONFERENCE GRANTS	WORLD CONGRESS OF PSYCHIATRIC GENETICS WITH EMPHASIS ON GENES FOR DRUG ABUSE	R13DA022792-01A1	DELSI LYNN E. - NEW YORK UNIVERSITY SCHOOL OF MEDICINE			\$30,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	2007 INTERNATIONAL PERIPHERAL NERVE SOCIETY MEETING AT SNOWBIRD, UTAH	R13NS059286-01	SMITH A GORDON - UNIVERSITY OF UTAH			\$28,000
NIH	CONFERENCE GRANTS	2007 NEUROTROPHIC FACTORS GORDON RESEARCH CONFERENCE	R13NS059067-01	GINTY DAVID D - GORDON RESEARCH CONFERENCES			\$28,000
NIH	CONFERENCE GRANTS	2007 NEW FRONTIERS IN CANCER DETECTION & DIAGNOSIS GORDON CONFERENCE	R13CA128386-01	BIGBEE WILLIAM L - GORDON RESEARCH CONFERENCES			\$27,000
NIH	CONFERENCE GRANTS	25TH NATIONAL NEUROTRAUMA SYMPOSIUM, 2007	R13NS060214-01	LYETH BRUCE G - UNIVERSITY OF CALIFORNIA DAVIS			\$26,000
NIH	CONFERENCE GRANTS	THIRD INTERNATIONAL CALCIVIRUS CONFERENCE	R13AI077221-01	JIANG XI - CHILDRENS HOSPITAL MED CTR (CINCINNATI)			\$25,210
NIH	CONFERENCE GRANTS	AQUATIC ANIMAL MODELS FOR HUMAN HEALTH STUDIES	R13RR024332-01	HINTON DAVID E - DUKE UNIVERSITY			\$25,000
NIH	CONFERENCE GRANTS	18TH-22ND ANNUAL MEETINGS AND SYMPOSIUM	R13DA015108-06	LIBERTO JOSEPH - AMERICAN ACADEMY OF ADDICTION PSYCHIATRY			\$25,000
NIH	CONFERENCE GRANTS	2007 CATECHOLAMINES GORDON RESEARCH CONFERENCE	R13DA023299-01	BECKER JILL B - GORDON RESEARCH CONFERENCES			\$25,000
NIH	CONFERENCE GRANTS	REWARD, COMPULSIONS AND HABIT FORMATION	R13DA023350-01	HABER SUZANNE N - UNIVERSITY OF ROCHESTER			\$25,000
NIH	CONFERENCE GRANTS	SIXTH ANNUAL MEETING OF THE INTERNATIONAL SOCIETY FOR THE PREVENTION OF TOBACCO 1	R13DA023818-01	CHOWDHURY PARIMAL - UNIVERSITY OF ARKANSAS MED SCIS LITL ROCK			\$25,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM FOR HEREDITARY SPASTIC PARAPLEGIA	R13NS060552-01	PINK JOHN K - UNIVERSITY OF MICHIGAN AT ANN ARBOR			\$25,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM ON NEURAL REGENERATION	R13NS060550-01	MADISON ROGER D - DUKE UNIVERSITY			\$25,000
NIH	CONFERENCE GRANTS	THE GLYCOPROTEOMES, SECOND INTERNATIONAL WORKSHOP ON ADVANCES IN PATHOGENESIS A	R13NS060555-01	WALKLEY STEVEN UPSHAW - YESHIVA UNIVERSITY			\$25,000
NIH	CONFERENCE GRANTS	HMO RESEARCH NETWORK 13TH ANNUAL CONFERENCE	R13CA128384-01	HORN BROOK MARK C - KAISER FOUNDATION RESEARCH INSTITUTE			\$24,992

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	2007 CASE CLEAR ANNUAL SPRING CONFERENCE	R13A076175-01	LEDERMAN MICHAEL M - CASE WESTERN RESERVE UNIVERSITY			\$23,160
NIH	CONFERENCE GRANTS	THIRD INTERNATIONAL WORKSHOP ON SEIZURE PREDICTION - FREIBURG, GERMANY, 2007	R1JNS060623-01	ZAVERTI HITTE P - YALE UNIVERSITY			\$23,000
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM ON CANCER METASTASIS AND THE LYMPHOVASCULAR SYSTEM	R13CA126430-01	LEONG STANLEY P L - UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$22,000
NIH	CONFERENCE GRANTS	A PROPOSAL FOR FUNDING FOR THE 17TH INTERNATIONAL SYMPOSIUM ON VON HIPPEL LINDAU D	R13CA126427-01	GRAFF JOYCE WILCOX - VHL FAMILY ALLIANCE			\$20,000
NIH	CONFERENCE GRANTS	AORTIC INTERNATIONAL MEETING	R13CA119920-02	MOHAMMED SULMA IBRAHIM - PURDUE UNIVERSITY WEST LAFAYETTE			\$20,000
NIH	CONFERENCE GRANTS	TRANSLATIONAL RESEARCH IN CANCER PREVENTION	R13CA132371-01	BRENNER DEAN E - UNIVERSITY OF MICHIGAN AT ANN ARBOR			\$20,000
NIH	CONFERENCE GRANTS	PATHOLOGY OF THE LABORATORY MOUSE	R13R017436-06	SUNDBERG JOHN PAUL - JACKSON LABORATORY			\$20,000
NIH	CONFERENCE GRANTS	14TH INTERNATIONAL CHRO WORKSHOP	R13A077194-01	NACHAMKIN IRVING - UNIVERSITY OF PENNSYLVANIA			\$20,000
NIH	CONFERENCE GRANTS	IMMUNOBIOLOGY OF INFLUENZA VIRUS INFECTION: APPROACHES FOR AN EMERGING ZOONOTIC D	R13A075970-01	TRIPP RALPH A - UNIVERSITY OF GEORGIA (UGA)			\$20,000
NIH	CONFERENCE GRANTS	RESPIRATORY VIRUSES OF ANIMALS CAUSING DISEASE IN HUMANS SCIENTIFIC CONFERENCE	R13A071688-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$20,000
NIH	CONFERENCE GRANTS	SIXTH INTERNATIONAL RESPIRATORY SYNCYTIAL VIRUS SYMPOSIUM	R13A075731-01	FALSEY ANN R - UNIVERSITY OF ROCHESTER			\$20,000
NIH	CONFERENCE GRANTS	ADDICTION AND THE BRAIN: ARE WE HARD WIRED TO ABUSE DRUGS	R13DA023351-01	FOWLER JOANNA S - BROOKHAVEN SCIENCE ASSOC-BROOKHAVEN LAB			\$20,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	7TH INTERNATIONAL CEREBRAL VASCULAR BIOLOGY CONFERENCE	R13NS060546-01	CHODORSKI ADAM - RHODE ISLAND HOSPITAL (PROVIDENCE, RI)			\$20,000
NIH	CONFERENCE GRANTS	ASNTF ANNUAL MEETING STUDENT TRAVEL AWARDS	R13NS059304-01	SUBRAMANIAN - THYAGARAJAN - PENNSYLVANIA STATE UNIV			\$20,000
NIH	CONFERENCE GRANTS	INTERNATIONAL CONGRESS FOR NEUROETHOLOGY PROPOSAL	R13NS060583-01	HERSHEY MED CTR - HARRIS-WARRICK RONALD M - INTERNATIONAL SOCIETY/NEUROETHOLOGY			\$20,000
NIH	CONFERENCE GRANTS	LYSOSOMAL DISEASE NETWORK - 3RD ANNUAL WORLD SYMPOSIUM	R13NS058236-01	WHITLEY CHESTER B - UNIVERSITY OF MINNESOTA TWIN CITIES			\$20,000
NIH	CONFERENCE GRANTS	NEUROTECHNOLOGY SATELLITE CONFERENCE FOR THE HEALTH CARE PROFESSIONAL POPULATION	R13NS058247-01A1	FRENCH JENNIFER - SOCIETY TO INCREASE MOBILITY, INC.			\$20,000
NIH	CONFERENCE GRANTS	THIRD INTERNATIONAL NEURAL ENGINEERING CONFERENCE 2007	R13NS059309-01	AKAY METIN - ARIZONA STATE UNIVERSITY-TEMPE CAMPUS			\$20,000
NIH	CONFERENCE GRANTS	VAS-COG 2007	R13NS060544-01	ROYALL DONALD R - UNIVERSITY OF TEXAS HLTH SCI CTR SAN ANT			\$20,000
NIH	CONFERENCE GRANTS	2007 VIRUSES & CELLS GORDON CONFERENCE	R13AB074257-01	GRIFIN DIANE E - GORDON RESEARCH CONFERENCES			\$19,800
NIH	CONFERENCE GRANTS	AMERSA ANNUAL NATIONAL CONFERENCE	R13DA015046-06	FRIEDMANN PETER D - ASSN/MEDICAL EDUC & RES IN SUBS ABUSE			\$19,500
NIH	CONFERENCE GRANTS	15TH ANNUAL INTERNATIONAL CONFERENCE ON MICROBIAL GENOMICS	R13AB077246-01	BLATTNER FREDERICK R - UNIVERSITY OF WISCONSIN MADISON			\$19,000
NIH	CONFERENCE GRANTS	"MODEL ORGANISMS TO HUMAN BIOLOGY: STRATEGIES FOR THE FUTURE OF GENETIC RESEARCH"	R13GM083370-01	SPRADLING ALLAN C - CARNEGIE INSTITUTION OF WASHINGTON, D.C.			\$19,000
NIH	CONFERENCE GRANTS	INFECTIOUS DISEASES IN AFRICA: MEASUREMENT OF IMMUNE RESPONSES	R13AB076027-01	FERRARI GUIDO - DUKE UNIVERSITY			\$18,800
NIH	CONFERENCE GRANTS	KEYSTONE SYMPOSIUM ON VIRAL IMMUNITY	R13AB075653-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$18,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	APS TRAVEL AWARD	R13NS059294-01	SLIKA KATHLEEN A - UNIVERSITY OF IOWA			\$18,000
NIH	CONFERENCE GRANTS	ALCOHOL & IMMUNOLOGY RESEARCH INTEREST GROUP (AIRIG) MEETING	R13AA017084-01	KOVACS ELIZABETH J - LOYOLA UNIVERSITY CHICAGO			\$17,750
NIH	CONFERENCE GRANTS	2007 GRC ON TB DRUG DEVELOPMENT	R13AB074075-01	RUBIN ERIC JOSEPH - GORDON RESEARCH CONFERENCES			\$17,000
NIH	CONFERENCE GRANTS	BIOACTIVE FOOD COMPONENTS, ALTERNATIVE MEDICINE AND CANCER CHEMOPREVENTION: RECE	R13CA13241-01	SINGH SHIVENDRA - UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$16,000
NIH	CONFERENCE GRANTS	FASEB SUMMER RESEARCH CONFERENCE ON LYSOPHOSPHOLIPID MEDIATORS IN HEALTH & DISEASE	R13CA128175-01	SPIEGEL SARAH - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$15,500
NIH	CONFERENCE GRANTS	INTERNATIONAL MD&M WORKSHOP IV	R13CA130594-01	JONES STEPHEN N - UNIV OF MASSACHUSETTS MED SCH WORCESTER			\$15,000
NIH	CONFERENCE GRANTS	RESEARCH PERSPECTIVES IN PSYCHONEUROIMMUNOLOGY	R13CA126254-01	SMITH ERIC M - UNIVERSITY OF TEXAS MEDICAL BR GALVESTON			\$15,000
NIH	CONFERENCE GRANTS	NINTH INTERNATIONAL CONGRESS ON TOXOPLASMOSIS	R13AB074299-01	STRIEPEN BORIS - UNIVERSITY OF GEORGIA (UGA)			\$15,000
NIH	CONFERENCE GRANTS	2007 MOLECULAR PHARMACOLOGY GORDON RESEARCH CONFERENCE	R13DA022784-01	VON ZASTROW MARK E - GORDON RESEARCH CONFERENCES			\$15,000
NIH	CONFERENCE GRANTS	CANNABINOID	R13DA023325-01	MACKIE KENNETH P - GORDON RESEARCH CONFERENCES			\$15,000
NIH	CONFERENCE GRANTS	NEUROBIOLOGY OF ADDICTION	R13DA022869-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$15,000
NIH	CONFERENCE GRANTS	FORWARD TO PROFESSORSHIP WORKSHOP FOR PRE-TENURED WOMEN AND UNDER-REPRESENTED MI	R13GM080942-01	HELLER RACHELLE S - GEORGE WASHINGTON UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	GNE 2007: GLOBAL NEUROENGINEERING 2007	R13NS059245-01	NICOLELIS MIGUEL A. L. - DUKE UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	INTERNATIONAL WORKSHOP: SENSORY EVALUATION OF PAIN AND ANALGESIA RESEARCH	R13NS058234-01	NEMENOV MIKHAIL I. - LASMED, LLC			\$15,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	NEURAL TUBE DEFECTS CONFERENCE 2007 AND BEYOND	R13NS060635-01	SPEER MARCY C. - DUKE UNIVERSITY			\$15,000
NIH	CONFERENCE GRANTS	THE TRANSIENT RECEPTOR POTENTIAL ION CHANNEL SUPERFAMILY	R13NS059294-01	ROBERTSON ANDREW D. - KEYSTONE SYMPOSIA			\$15,000
NIH	CONFERENCE GRANTS	A NEW ANNUAL ALCOHOL RESEARCH FORUM: GUZE SYMPOSIUM	R13AA013717-06A1	BUCHOLZ KATHLEEN K. - WASHINGTON UNIVERSITY			\$14,920
NIH	CONFERENCE GRANTS	2007 ANNUAL SOCIETY FOR VECTOR ECOLOGICAL CONFERENCE, SPRINGFIELD, IL	R13AI075926-01	MULLA MIR - UNIVERSITY OF CALIFORNIA RIVERSIDE			\$14,175
NIH	CONFERENCE GRANTS	FORTIETH ANNUAL MEETING OF THE SOCIETY FOR LEUKOCYTE BIOLOGY	R13AI075939-01	ROLLINS BARRETT J. - SOCIETY FOR LEUKOCYTE BIOLOGY			\$14,000
NIH	CONFERENCE GRANTS	KEYSTONE SYMPOSIUM ON LEUKOCYTE TRAFFICKING	R13AI075716-01	ROBERTSON ANDREW D. - KEYSTONE SYMPOSIA			\$14,000
NIH	CONFERENCE GRANTS	THE MOLECULAR AND INTEGRATIVE BASIS FOR GASTROINTESTINAL DEVELOPMENT, HOMEOSTASIS	R13DK077430-01	MCCORMICK BETH A. - MASSACHUSETTS GENERAL HOSPITAL			\$14,000
NIH	CONFERENCE GRANTS	WORKSHOP ON MOLECULAR IMAGING AGENTS	R13CA126365-01	VERA DAVID R. - UNIVERSITY OF CALIFORNIA SAN DIEGO			\$13,000
NIH	CONFERENCE GRANTS	2007 GRADIENT SENSING & DIRECTED CELL MIGRATION GRC	R13GM079853-01	SEGALL JEFFREY E. - GORDON RESEARCH CONFERENCES			\$13,000
NIH	CONFERENCE GRANTS	TUBERCULOSIS: FROM LAB RESEARCH TO FIELD TRIALS	R13AI072803-01	ROBERTSON ANDREW D. - KEYSTONE SYMPOSIA			\$12,700
NIH	CONFERENCE GRANTS	FASEB CONFERENCE ON ASSEMBLY OF THE MITOCHONDRIAL RESPIRATORY CHAIN	R13OM081989-01	WINGE DENNIS R. - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$12,500
NIH	CONFERENCE GRANTS	AUTUMN IMMUNOLOGY CONFERENCE	R13AI074121-01	HOGQUIST KRISTIN A. - UNIVERSITY OF MINNESOTA TWIN CITIES			\$12,000
NIH	CONFERENCE GRANTS	SECOND INTERNATIONAL WORKSHOP ON MICROSPORIDIA FROM VERTEBRATE AND INVERTEBRATE H	R13AI074290-01	WEISS LOUIS M. - YESHIVA UNIVERSITY			\$12,000
NIH	CONFERENCE GRANTS	2ND ANNUAL GLYCOCONJUGATE ANALYSIS WORKSHOP	U13RR024368-01	REINHOLD VERNON NYE - UNIVERSITY OF NEW HAMPSHIRE			\$11,994

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	5TH INTERNATIONAL SYMPOSIUM ON THE INTRADUCTAL APPROACH TO BREAST CANCER	R13CA12835-01	LOVE SUSAN M. DR. SUSAN LOVE RESEARCH FOUNDATION			\$11,000
NIH	CONFERENCE GRANTS	CONFERENCE SUPPORT: THE 13TH INTERNATIONAL DRUG DELIVERY SYMPOSIUM	R13CA128063-01	GRANGER DAVID W. - UNIVERSITY OF UTAH			\$11,000
NIH	CONFERENCE GRANTS	MCMSKII: MARKOV CHAIN MONTE CARLO IN THEORY AND PRACTICE	R13CA110915-02	CARLIN BRADLEY P. - UNIVERSITY OF MINNESOTA TWIN CITIES			\$11,000
NIH	CONFERENCE GRANTS	MEMPHIS BIOMAGING SYMPOSIUM	R13CA132504-01	WILSON THADDEUS ANDREW - UNIVERSITY OF TENNESSEE HEALTH SCI CTR			\$10,425
NIH	CONFERENCE GRANTS	2007 MECHANISMS OF CELL SIGNALING GORDON RESEARCH CONFERENCE	R13CA130041-01	CHERNOFF JONATHAN D. - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	AMERICAN PSYCHOSOCIAL ONCOLOGY SOCIETY 4TH ANNUAL CONFERENCE	R13CA126310-01	MCCORKLE RUTH - AMERICAN PSYCHOSOCIAL ONCOLOGY SOCIETY			\$10,000
NIH	CONFERENCE GRANTS	ANNUAL CONFERENCE: AMERICAN SOCIETY OF PREVENTIVE ONCOLOGY	R13CA094927-06	TRENTHAM-DIETZ AMY - UNIVERSITY OF WISCONSIN MADISON			\$10,000
NIH	CONFERENCE GRANTS	KEYSTONE MEETING ON TGF-BETA FAMILY IN HOMEOSTASIS AND DISEASE	R13CA130244-01	ROBERTSON ANDREW D. - KEYSTONE SYMPOSIA			\$10,000
NIH	CONFERENCE GRANTS	TUMOR MICROENVIRONMENT: PROGRESSION, THERAPY AND PREVENTION	R13CA128588-01	DECLERCK YVES A. - AMERICAN ASSOCIATION FOR CANCER RESEARCH			\$10,000
NIH	CONFERENCE GRANTS	US-JAPAN SEMINAR - FRONTIERS IN MARINE NATURAL PRODUCTS RESEARCH	R13CA128082-01	IRELAND CHRIS M. - UNIVERSITY OF UTAH			\$10,000
NIH	CONFERENCE GRANTS	2007 CARBOHYDRATES GORDON RESEARCH CONFERENCE	R13R014093-01	WANG PENG GEORGE - GORDON RESEARCH CONFERENCES			\$10,000
NIH	CONFERENCE GRANTS	11TH INTERNATIONAL CONGRESS OF IMMUNOLOGY	R13A075941-01	ABBAS ABUL K. - UNIVERSITY OF CALIFORNIA SAN FRANCISCO			\$10,000
NIH	CONFERENCE GRANTS	BIOLOGY OF B CELLS IN HEALTH AND DISEASE	R13A072804-01	ROBERTSON ANDREW D. - KEYSTONE SYMPOSIA			\$10,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	IMAGING IMMUNE RESPONSES	R13AB74292-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA				\$10,000
NIH	CONFERENCE GRANTS	IMMUNOLOGIC MEMORY	R13AB72830-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA				\$10,000
NIH	CONFERENCE GRANTS	INTRACELLULAR AND DENDRITIC CELL SIGNALING IN REGULATORY T CELLS	R13AB74295-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA				\$10,000
NIH	CONFERENCE GRANTS	3RD ASM CONFERENCE ON CELL-CELL COMMUNICATION IN BACTERIA	R13AB72874-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA				\$10,000
NIH	CONFERENCE GRANTS	CONFERENCE PROPOSAL - ION CHANNEL REGULATION	R13GM082170-01	FUQUA WILLIAM C - AMERICAN SOCIETY FOR MICROBIOLOGY				\$10,000
NIH	CONFERENCE GRANTS	EIGHTH INTERNATIONAL CONFERENCE ON SYSTEMS BIOLOGY (ICSB 2007)	R13GM083497-01	BOLOTINA VICTORIA M - FEDERATION OF AMER SOC FOR EXPER BIOLOGY				\$10,000
NIH	CONFERENCE GRANTS	2007 CHRONOBIOLOGY GORDON RESEARCH CONFERENCE	R13NS059218-01	HUCKA MICHAEL - CALIFORNIA INSTITUTE OF TECHNOLOGY				\$10,000
NIH	CONFERENCE GRANTS	COLD SPRING HARBOR 72ND SYMPOSIUM QUANTITATIVE BIOLOGY: CLOCKS & RHYTHMS	R13NS058217-01	TAKAHASHI JOSEPH S - GORDON RESEARCH CONFERENCES				\$10,000
NIH	CONFERENCE GRANTS	NEUROBIOLOGY OF DROSOPHILA CONFERENCE	R13NS060548-01	STEWART DAVID J - COLD SPRING HARBOR LABORATORY				\$10,000
NIH	CONFERENCE GRANTS	THROMBOSPONDINS AND OTHER MATRICELLULAR PROTEINS IN TISSUE ORGANIZATION AND HEMEO	R13CA128383-01	LAWLER JOHN W - FEDERATION OF AMER SOC FOR EXPER BIOLOGY				\$9,000
NIH	CONFERENCE GRANTS	4TH ORTHOMYXOVIRUS RESEARCH CONFERENCE	R13AB74297-01	SCHULTZ-CHERRY STACEY L - UNIVERSITY OF WISCONSIN MADISON				\$9,000
NIH	CONFERENCE GRANTS	CHALLENGES OF GLOBAL VACCINE DEVELOPMENT	R13AB76090-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA				\$9,000
NIH	CONFERENCE GRANTS	DRUGS AGAINST PROTOZOAN PARASITES SCIENTIFIC CONFERENCE	R13AB71682-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA				\$9,000
NIH	CONFERENCE GRANTS	MID-ATLANTIC MICROBIAL PATHOGENESIS MEETING	R13AB73025-01	WOZNIAK DANIEL J - WAKE FOREST UNIVERSITY HEALTH SCIENCES				\$9,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	2007 CB2 CANNABINOID MEETING	R13DA023352-01	MACKIE KENNETH P - INDIANA UNIVERSITY BLOOMINGTON			\$8,800
NIH	CONFERENCE GRANTS	CONFERENCE ON IMMUNE SUPPRESSION IN CANCER	R13CA126360-01	GABRILOVICH DMITRY I - H. LEE MORFITT CANCER CTR & RES INST			\$8,000
NIH	CONFERENCE GRANTS	WNT SIGNALING IN DEVELOPMENT AND DISEASE	R13CA128448-01	WILLERT KARL H - UNIVERSITY OF CALIFORNIA SAN DIEGO			\$8,000
NIH	CONFERENCE GRANTS	2007 IMMUNOBIOLOGY AND IMMUNOCHEMISTRY GORDON RESEARCH CONFERENCE	R13AM074302-01	KRONENBERG MITCHELL - GORDON RESEARCH CONFERENCES			\$8,000
NIH	CONFERENCE GRANTS	2007 MIDWINTER CONFERENCE OF IMMUNOLOGISTS AT ASILONAR	R13AM074076-01	UTTENBOGAART CHRISTEL H - UNIVERSITY OF CALIFORNIA LOS ANGELES			\$8,000
NIH	CONFERENCE GRANTS	INTERNATIONAL LEPTOSPIROSIS SOCIETY MEETING 2007	R13AM075971-01	VINETZ JOSEPH M - UNIVERSITY OF CALIFORNIA SAN DIEGO			\$8,000
NIH	CONFERENCE GRANTS	2007 PROTEIN TRANSPORT ACROSS MEMBRANES GORDON CONFERENCE	R13GM080876-01	KOEHLER CARLA M - GORDON RESEARCH CONFERENCES			\$8,000
NIH	CONFERENCE GRANTS	ASCB SUMMER MEETING: DYNAMIC INTERPLAY BETWEEN CYTOSKELETAL AND MEMBRANE SYSTEMS	R13GM080938-01	DRUBIN DAVID - AMERICAN SOCIETY FOR CELL BIOLOGY			\$8,000
NIH	CONFERENCE GRANTS	KEYSTONE MEETINGS ON AUTOPHAGY AND CELL DEATH PATHWAYS	R13GM080958-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA			\$8,000
NIH	CONFERENCE GRANTS	TWENTY FOURTH FUNGAL GENETICS CONFERENCE	R13AM074316-01	ORBACH MARC J - UNIVERSITY OF ARIZONA			\$7,700
NIH	CONFERENCE GRANTS	INTERNATIONAL SYMPOSIUM ON JUVENILE MYELOMONOCYTIC LEUKEMIA	R13CA132568-01	LOH MIGNON LEE-CHEUN - JMML FOUNDATION			\$7,500
NIH	CONFERENCE GRANTS	NEW DIRECTIONS IN THYROID CANCER RESEARCH AND TREATMENT	R13CA132472-01	WELLS SAMUEL A - WASHINGTON UNIVERSITY			\$7,500
NIH	CONFERENCE GRANTS	2007 STAPHYLOCOCCAL DISEASES GORDON CONFERENCE	R13AM074148-01	BAYLES KENNETH W - GORDON RESEARCH CONFERENCES			\$7,500
NIH	CONFERENCE GRANTS	MAMMARY GLAND BIOLOGY GRC	R13CA128408-01	ANDERSON STEVEN M - GORDON RESEARCH CONFERENCES			\$7,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	THE MACROPHAGE: HOMEOSTASIS, IMMUNOREGULATION AND DISEASE	R13AD74291-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA		\$7,000
NIH	CONFERENCE GRANTS	2007 MECHANISMS OF MEMBRANE TRANSPORT GORDON CONFERENCE	R13GM080814-01	MALONEY PETER C - GORDON RESEARCH CONFERENCES		\$7,000
NIH	CONFERENCE GRANTS	ADVANCE IN COMPUTATIONAL MOTOR CONTROL	R13NS059296-01	TODOROV EMANUEL - UNIVERSITY OF CALIFORNIA SAN DIEGO		\$7,000
NIH	CONFERENCE GRANTS	2007 POLYAMINES GORDON CONFERENCE AND GRADUATE RESEARCH SEMINAR	R13AD74185-01	PHILLIPS MARGARET A - GORDON RESEARCH CONFERENCES		\$6,500
NIH	CONFERENCE GRANTS	CONFERENCE ON THE BASIC CELL AND MOLECULAR BIOLOGY OF CILIA AND FLAGELLA AS RELATE	R13GM082119-01	ROSENBAUM JOEL L - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$6,500
NIH	CONFERENCE GRANTS	13TH INTERNATIONAL CONGRESS OF RADIATION RESEARCH	R13CA128449-01	DEWHIRST MARK W - DUKE UNIVERSITY		\$6,000
NIH	CONFERENCE GRANTS	2007 PHAGOCYTES	R13AD075730-01	SWANSON JOEL A - GORDON RESEARCH CONFERENCES		\$6,000
NIH	CONFERENCE GRANTS	APOPTOTIC CELL RECOGNITION & CLEARANCE 2007 GORDON RESEARCH CONFERENCE	R13AD075942-01	RAVICHANDRAN KODI S - GORDON RESEARCH CONFERENCES		\$6,000
NIH	CONFERENCE GRANTS	CTS-IPITA-IXA 2007 JOINT CONFERENCE	R13AD076089-01	HERING BERNHARD J - UNIVERSITY OF MINNESOTA TWIN CITIES		\$6,000
NIH	CONFERENCE GRANTS	MIDWEST REGIONAL PAIN INTEREST GROUP MEETING	R13NS060547-01	GEREAU ROBERT W - WASHINGTON UNIVERSITY		\$6,000
NIH	CONFERENCE GRANTS	WORKSHOP - IMCICF: THE MANAGEMENT OF SYNCHROTRON IMAGE DATA	R13RR023192-01 A1	BERNSTEIN HERBERT J - DOWLING COLLEGE		\$5,900
NIH	CONFERENCE GRANTS	A BLACK MAN CAN...FIGHT PROSTATE CANCER	R13CA126369-01	WILLIAMS-BROWN SHANITA D - MOREHOUSE SCHOOL OF MEDICINE		\$5,000
NIH	CONFERENCE GRANTS	CELL DEATH	R13CA130253-01	GRODZICKER TERRI L - COLD SPRING HARBOR LABORATORY		\$5,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	CELL GROWTH & PROLIFERATION GORDON RESEARCH CONFERENCE	R13CA130595-01	YAFFE MICHAEL B. - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	COLD SPRING HARBOR LABORATORY CONFERENCE ON THE UBIQUITIN FAMILY	R13CA126007-01	GRODZICKER TERRI L. - COLD SPRING HARBOR LABORATORY		\$5,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE ON PROTEIN KINASES	R13CA130582-01	BLENIS JOHN - FEDERATION OF AMER SOC FOR EXPR BIOLOGY		\$5,000
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON NUCLEAR STRUCTURE AND CANCER	R13CA128166-01	STEIN GARY S. - FEDERATION OF AMER SOC FOR EXPR BIOLOGY		\$5,000
NIH	CONFERENCE GRANTS	2007 ANTIMICROBIAL PEPTIDES GORDON CONFERENCE	R13AB074086-01	GALLO RICHARD L. - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	STRENGTHENING SOCIETIES INFECTIOUS DISEASE DEFENSES: DIAGNOSTICS IN EMERGING MARK	R13AB077496-01	FELDGARDEN MICHAEL - ALLIANCE/PRUDENT USE OF ANTIBIOTICS		\$5,000
NIH	CONFERENCE GRANTS	THE FOURTH INTERNATIONAL LEUKOCYTE SIGNAL TRANSDUCTION WORKSHOP: CLINICAL IMPLICA	R13AB074315-01	ALTMAN AMINON - LA JOLLA INST FOR ALLERGY & IMMUNOLGY		\$5,000
NIH	CONFERENCE GRANTS	TOLERANCE IN TRANSPLANTATION AND AUTOIMMUNITY	R13AB075649-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA		\$5,000
NIH	CONFERENCE GRANTS	2007 ELECTRON DISTRIBUTION & CHEMICAL BONDING GORDON RESEARCH CONFERENCE	R13OM082163-01	GATTI CARLO - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	2007 MOTILE AND CONTRACTILE SYSTEMS	R13OM080974-01	TITUS MARGARET A - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	2007 PROTEINS GORDON RESEARCH CONFERENCE	R13OM080752-01	HILL CHRISTOPHER P. - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	ALBANY 2007: THE 15TH CONVERSATION	R13OM081869-01	SARMA RAMASWAMY H. - STATE UNIVERSITY OF NEW YORK AT ALBANY		\$5,000
NIH	CONFERENCE GRANTS	ALCOHOL AND TRAUMA 2007	R13OM080954-01	KOVACS ELIZABETH J - LOYOLA UNIVERSITY CHICAGO		\$5,000
NIH	CONFERENCE GRANTS	BIOACTIVE LIPIDS IN THE LIPIDOMICS ERA	R13OM080134-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA		\$5,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	CONFERENCE PROPOSAL TO SUPPORT FASEB CONFERENCE ON CILIATE MOLECULAR BIOLOGY	R13GM081940-01	PRICE CAROLYN M - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$5,000
NIH	CONFERENCE GRANTS	FASEB CONFERENCE: TRANSPORT ATPASES	R13GM080136-01	SWEADNER KATHLEEN J - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$5,000
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON HELICASE AND NTP-DRIVEN NUCLEIC ACID MOTORS: STRUCTURE	R13GM080902-01	LOHMAN TIMOTHY M - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$5,000
NIH	CONFERENCE GRANTS	FRONTIERS OF NMR IN MOLECULAR BIOLOGY X SCIENTIFIC CONFERENCE	R13GM079639-01	ROBERTSON ANDREW D - KEYSTONE SYMPOSIA		\$5,000
NIH	CONFERENCE GRANTS	FUNCTIONAL MATERIALS THROUGH BOTTOM-UP SELF-ASSEMBLY - 2007 SUPRAMOLECULES & ASSE	R13GM080982-01	TEXTER JOHN - EASTERN MICHIGAN UNIVERSITY		\$5,000
NIH	CONFERENCE GRANTS	MODELING OF PROTEIN INTERACTIONS 2007	R13GM083480-01	VAJDA SANDOR - BOSTON UNIVERSITY		\$5,000
NIH	CONFERENCE GRANTS	NUCLEIC ACIDS GORDON CONFERENCE, 2007	R13GM082686-01	PUGLISI JOSEPH D - STANFORD UNIVERSITY		\$5,000
NIH	CONFERENCE GRANTS	ROADMAP MEMBRANE PROTEIN PRODUCTION AND TECHNOLOGIES MEETING	R13GM082172-01	STEVENS RAYMOND C - SCRIPPS RESEARCH		\$5,000
NIH	CONFERENCE GRANTS	SIGNAL TRANSDUCTION WITHIN THE NUCLEUS GORDON CONFERENCE	R13GM074559-02	YORK JOHN D - GORDON RESEARCH CONFERENCES		\$5,000
NIH	CONFERENCE GRANTS	FASEB SUMMER RESEARCH CONFERENCE ON LIPID SIGNALING PATHWAYS IN CANCER	R13CA130959-01	TOKER ALEX - FEDERATION OF AMER SOC FOR EXPER BIOLOGY		\$4,352
NIH	CONFERENCE GRANTS	4TH INTERNATIONAL CONFERENCE ON ONCOLYTIC VIRUSES AS CANCER THERAPEUTICS	R13CA128251-01	PENG KAH-WHYE - MAYO CLINIC COLL OF MEDICINE, ROCHESTER		\$4,000
NIH	CONFERENCE GRANTS	CSHL CONFERENCE ON PHOSPHORYLATION, SIGNALING AND DISEASE	R13CA126443-01	STEWART DAVID J - COLD SPRING HARBOR LABORATORY		\$4,000
NIH	CONFERENCE GRANTS	INTEGRATED FUNCTIONAL GENOMICS: ON THE ROAD TO LEISHMANIASIS CONTROL DORMY HOUSE	R13AI077297-01	MCMAHON PRAIT DIANE - YALE UNIVERSITY		\$4,000

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FY 2007 Non-Competitive Grants

NIH	CONFERENCE GRANTS	2007 CELL BIOLOGY OF METALS GORDON RESEARCH CONFERENCE	R13DK080626-01	DANCE ANDREW B. - GORDON RESEARCH CONFERENCES			\$4,000
NIH	CONFERENCE GRANTS	NATIONAL PHARMACOLOGY DIRECTORS OF GRADUATE PROGRAMS MEETING	R13OM080977-01	BARNETT JOEY V. - VANDERBILT UNIVERSITY			\$4,000
NIH	CONFERENCE GRANTS	GENETIC RECOMBINATION AND CHROMOSOME REARRANGEMENTS	R13CA130398-01	SYMINGTON LORRAINE S. - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$3,500
NIH	CONFERENCE GRANTS	SYMPOSIUM ON SENESCENCE, AGING AND CANCER	R13CA130653-01	NILSEN-HAMILTON MARIT - IOWA STATE UNIVERSITY			\$3,500
NIH	CONFERENCE GRANTS	AFRO-CARIBBEAN CONSORTIUM ON VIRAL AND ENVIRONMENTAL RISK FACTORS FOR CANCER	R13CA130596-01	BAGIN CAMILLE C. - UNIVERSITY OF PITTSBURGH AT PITTSBURGH			\$3,000
NIH	CONFERENCE GRANTS	CHROMATIN STRUCTURE AND DNA REPAIR	R13CA130756-01	PANDITA TEJ K. - WASHINGTON UNIVERSITY			\$3,000
NIH	CONFERENCE GRANTS	CSHL MECHANISMS OF EUKARYOTIC TRANSCRIPTION CONFERENCE	R13CA130227-01	GRODZICKER TERRIL L. - COLD SPRING HARBOR LABORATORY			\$3,000
NIH	CONFERENCE GRANTS	2007 ANTIGEN CROSS- PRESENTATION	R13AI074087-01	SHIVASTAVA PRAMOD K. - GORDON RESEARCH CONFERENCES			\$3,000
NIH	CONFERENCE GRANTS	FASEB SUMMER CONFERENCE ON SIGNAL TRANSDUCTION IN THE IMMUNE SYSTEM	R13AI074219-01	LOWELL CLIFFORD A. - FEDERATION OF AMER SOC FOR EXPER BIOLOGY			\$3,000
NIH	CONFERENCE GRANTS	2007 MOLECULAR MEMBRANE BIOLOGY GRC	R13OM080747-01	GLICK BENJAMIN S. - GORDON RESEARCH CONFERENCES			\$3,000
NIH	CONFERENCE GRANTS	2007 PLANT METABOLIC ENGINEERING GORDON CONFERENCE & GRADUATE RESEARCH SEMINAR	R13OM080770-01	GROTEWOLD ERICH - GORDON RESEARCH CONFERENCES			\$3,000
NIH	CONFERENCE GRANTS	GRADUATE STUDENT SYMPOSIUM PLANNING COMMITTEE'S SYMPOSIUM AT THE AMERICAN CHEMICAL	R13OM080975-01	SINGER SHERWIN JEFFREY - OHIO STATE UNIVERSITY			\$3,000
NIH	CONFERENCE GRANTS	2007 MICROBIAL POPULATION BIOLOGY	R13AI074296-01	DEAN ANTHONY M. - GORDON RESEARCH CONFERENCES			\$2,500
NIH	CONFERENCE GRANTS	2007 MOLECULAR & CELLULAR BIOENERGETICS	R13OM080744-01	DALDAL FEYZI - GORDON RESEARCH CONFERENCES			\$2,000

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FY 2007 Non-Competitive Grants

NIH Total =	\$2,971,072
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FY 2007 Non-Competitive Grants

Office on Women's Health (OWH)					
OWH	OWH Steps to Healthier Girls Program	OWH Steps to Healthier Girls Program	SHOWH090001	Girl Scouts of the USA	
				N	Y
					\$93,000
					OWH Total = \$93,000

FY 2007 Non-Competitive Grants

Substance Abuse and Mental Health Services Administration (SAMHSA)				
SAMHSA	Child Mental Health Supplement	San Francisco Children's System of Care	3 SM054494-06-1	SAN FRANCISCO DEPT OF PUBLIC HEALTH
SAMHSA	Child Mental Health Supplement	Trauma-Informed System of Care for Children	3 SM057045-03-1	MAINE STATE DEPT/HEALTH/HUMAN SERVS
SAMHSA	Child Mental Health Supplement	BC-SCORES	3 SM057057-03-1	BEAVER COUNTY OFFICE OF MH AND MR
SAMHSA	Child Mental Health Supplement	Project Bloom	3 SM054471-06-1	COLORADO STATE DEPT OF HUMAN SERVICES
SAMHSA	Child Mental Health Supplement	Child MH Initiative - Louisiana Says YES to Children w/ MH Needs and Their Families	3 SM056050-05	LOUISIANA STATE DEPT OF HLTH & HOSPITALS
SAMHSA	Child Mental Health Supplement	Project TAPESTRY: Weaving Solutions for Child Mental Health	3 SM056055-05	CUYAHOGA COUNTY BOARD OF COMMISSIONERS
SAMHSA	Child Mental Health Supplement	Erie County Family Voices	3 SM056261-04	ERIE COUNTY MENTAL HEALTH DEPARTMENT
SAMHSA	Child Mental Health Supplement	Male Town Family Network: A System of Care for Maury County, TN	3 SM057010-03-1	TENNESSEE STATE DEPT OF MH/DEVEL DISAB
SAMHSA	Child Mental Health Supplement	Child Mental Health Initiative	3 SM057011-03-1	CALIFORNIA RURAL INDIAN HEALTH BOARD
SAMHSA	Child Mental Health Supplement	McHenry Co. Child/Adolescent Recovery Experience (CARE)	3 SM057015-03-1	ILLINOIS STATE DEPARTMENT OF HUMAN SVCS
SAMHSA	Child Mental Health Supplement	Harris County Alliance for Children and Families	3 SM057024-03-1	COUNTY OF HARRIS
SAMHSA	Child Mental Health Supplement	Central Minnesota Children's Mental Hlth Continuum of Care Delivery Sys	3 SM057034-03-1	CENTRAL MINNESOTA MENTAL HEALTH CENTER
SAMHSA	Child Mental Health Supplement	Positive Education Partnership	3 SM057060-03-1	RHODE ISLAND STATE DEPT FOR CHILD/FAMILY
SAMHSA	Child Mental Health Supplement	Partnership for Kids/PARK	3 SM054502-06	CONNECTICUT ST DEPT OF CHILDREN/FAMILIES
SAMHSA	Child Mental Health Supplement	Child Mental Health Initiative - ACTION	3 SM057014-03-1	ARKANSAS STATE DEPT OF HLTH & HUMAN SVCS
SAMHSA	Child Mental Health Supplement	Child Mental Health Initiative	3 SM057025-02-1	MISSISSIPPI STATE DEPT OF MTL HLTH
SAMHSA	Child Mental Health Supplement	Children's Voices: Family Choices, Community Solutions*	3 SM054497-06	FORT WORTH CITY PUBLIC HEALTH DEPT
SAMHSA	Child Mental Health Supplement	Project Ho' opohala- Transition to Adulthood	3 SM057063-03-1	HAWAII STATE DEPARTMENT OF HEALTH
SAMHSA Total =				\$1,727,944

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CHILDREN'S HOSPITAL GME

Ms. Roybal-Allard: Independent Children's Hospitals currently train 35% of all Pediatricians, 50% of all Pediatric Specialists, and the majority of all Pediatric Research Scientists. These hospitals do not have the operational funding available to them to cover the full costs of training these physicians, and therefore rely heavily on the Children's Hospital Graduate Medical Education Program. In California we have seven children's hospitals that receive about 10 percent of the total funds available for the Children's Hospital Graduate Medical Education program, and your budget proposes to eliminate this program.

My understanding is that the Children's Hospital GME program is the only federal source of funds available to the children's hospitals to help pay for the costs associated with training the next generation of pediatric specialists, but the administration has stated that the children's hospitals already get paid for GME by other sources. Can you tell me what other sources pay for GME for these children's hospitals, and how much these payments are for?

Secretary Leavitt: Children's hospitals also use patient care revenue from Medicaid and private insurers, as well as charitable contributions, to support their teaching and research missions. A 1998 survey conducted by the National Conference of State Legislatures found that nearly all states in which medical schools are located make some level of special payments to teaching hospitals under the Medicaid program. In addition, Children's hospitals are more likely to have positive profit margins than other hospitals. In 2000, 74 percent of children's hospitals had positive margins, compared to 67 percent of all hospitals, and 59 percent of major teaching hospitals.

Ms. Roybal-Allard: Have you looked at what impact the loss of Children's Hospital GME would have on the total operating budgets for children's hospitals?

Secretary Leavitt: An analysis of the impact of loss of Children's Hospital GME has not been conducted. The data to conduct such an analysis is not available. In addition, any analysis would need to consider potential changes in level of activity (costs) and other funding sources (revenues) – factors which are currently unknown – to estimate the full impact on their operating budgets.

Ms. Roybal-Allard: Do you have figures that estimate the reduction in residency slots given the proposed budget?

Secretary Leavitt: There are no data that can allow an assessment of the reduction in the number of slots, if any. In FY 2007, freestanding children's teaching hospitals reported training more than 5,000 full time equivalent interns, residents and fellows. These interns, residents and fellows serve the hospitals' teaching and research mission and as such it is not clear that a reduction in Federal funding would result in a reduction in slots.

MEDICARE PART D AND DUAL ELIGIBLES

Ms. Roybal-Allard: I am concerned about continuing Part D enrollment issues and the challenges confronted by dual eligibles with mental disabilities in the MMA. For example, according to the Kaiser Family Foundation, well over 3 million persons were eligible to receive low income subsidies under Part D last year, but were not, in fact, receiving them. In addition, the American Psychiatric Institute for Research and Education reported in 2007 that 61% of dual eligibles with serious mental illnesses have problems with accessing their medications.

What is CMS doing to help dual eligible persons with mental illnesses, Alzheimer's disease and mental retardation receive the low income subsidies owed them, and navigate the complicated Part D enrollment and appeal processes?

Secretary Leavitt: One of the main objectives of the Medicare Prescription Drugs, Improvement and Modernization Act of 2003 (MMA) was to provide the greatest assistance to those with the greatest need. The low income subsidy (LIS) provides substantial help to Medicare beneficiaries with limited incomes: a federal premium subsidy ranging from 25 to 100 percent of the monthly premium cost for qualified plans, and minimal cost-sharing for covered drugs. Dual eligible beneficiaries are automatically eligible for LIS, meaning they do not have to fill out any sort of additional application to receive the subsidy. Additionally, dual eligible individuals are automatically enrolled into a Part D plan. To assist these individuals with their specific healthcare needs, CMS is working with:

- State Health Insurance Assistance Programs (SHIPs) across the country to allocate part of their grants to foster local partnership efforts, including relationships with the mental health community and mental health organizations and to engage in outreach to better reach, inform, and assist beneficiaries with disabilities. In 2007, CMS required that SHIPs submit a program budget demonstrating that at least 5% of their funding is directed toward personalized pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities. CMS also mandated that all SHIP Directors attend a training to enhance SHIPs reach and service to beneficiaries with mental disabilities through a community-based partnership network serving these individuals. Lastly, CMS requires SHIPs to demonstrate how they are working to assist these individuals over the course of their grant period. In the FY2008 Grant Year, CMS will continue to advance this effort and again require that SHIPs submit program budgets allocating at least 5% of federal SHIP funding for assistance to low-income dual eligible persons with mental disabilities.
- Aging & Disability Resource Center to work with disability groups to specifically provide access to benefits, counseling and services for individuals. The ADRC assists approximately 30% of the US population in over 957 counties nationwide.

- The Administration on Aging (AoA) and n4a through an Interagency Agreement to conduct outreach to find and encourage applications for LIS to beneficiaries who may be eligible for the extra help. Through this effort, about a third of the contractors are specifically targeting individuals of mental or cognitive illnesses in their outreach.
- Medicare Access for Patients – Rx (MAPRx) coalition to provide information and help beneficiaries get access to the medications they need. This coalition is comprised of 27 organizations and other coalitions, including Access to Benefits Coalition, Alzheimer’s Association, Mental Health America and National Alliance for the Mentally Ill. Some specific materials available through this partnership include a Medicare Rx pocket guide for beneficiaries with mental illness, frequently asked questions, workbook for enrollment, consideration points for selecting plans for Alzheimer’s patients and coverage tip sheets.
- Members of the disability and LIS advocacy community to bring Medicare information to beneficiaries and/or their providers and caregivers. Currently, we are encouraging these organizations to participate in a targeted but coordinated outreach and education effort around LIS and open enrollment, including dual eligible individuals.
- Partners such as American Psychiatric Association to provide information specific to Part D formularies and plan appeal processes to psychiatrists and others who prescribe drugs used by people with mental illness. In addition, other partners, including the Mental Health Association, the National Alliance for the Mentally Ill, and the National Council on Community Behavioral Healthcare participate in routine CMS teleconferences to share information pertinent to this beneficiary audience.

Ms. Roybal-Allard: What outreach is being undertaken on behalf of these dual eligibles, and why are they experiencing such a high rate of problems accessing their medications?

Secretary Leavitt: Beginning in 2005, Medicare embarked on a multi-faceted campaign to reach out to the more than 42 million people with Medicare, with a special emphasis on reaching those beneficiaries potentially eligible for LIS. Medicare’s partners, including grassroots organizations, local, State and Federal agencies, State Health Insurance Assistance Programs (SHIPs), the faith community, and individual volunteers sponsored and attended thousands of Medicare events and opportunities across the country for people to get personalized assistance.

CMS outreach specific to dual eligible individuals include:

- Working with members of the disability and LIS community to bring Medicare information to beneficiaries and/or their providers and caregivers. Through regular teleconferences, CMS continues to engage these partners to discuss and address education and outreach efforts to encourage beneficiaries of mental and cognitive illnesses to navigate the healthcare system and utilize the coverage available to them.
- Directing SHIPs to allocate part of their grants to foster local partnership efforts, including relationships with the mental health community and mental health organizations and to engage in outreach to better reach, inform, and assist beneficiaries with disabilities. In the FY 2008 Grant Year, CMS will continue to advance this effort and again require that SHIPs submit program budgets allocating at least 5% of federal SHIP funding for assistance to low-income dual eligible persons with mental disabilities.
- Collaborating with states and monitoring the 450,000 beneficiaries who lost their deemed status to see how many reacquire low income subsidy assistance. As of February 2008, 45% of those losing deemed status qualified and are receiving partial low income subsidy assistance.

Ms. Roybal-Allard: Does your budget contain specific funds to continue making one-on-one counseling available to this population in a setting that is both accessible and appropriate to their disability needs?

Secretary Leavitt: Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) (P.L. 101-508, codified at 42 USC 1395 b-4) authorizes CMS to make grants to States to fund State Health Insurance Assistance Programs (SHIPs). As one-on-one counseling is a method to help beneficiaries navigate their health plan options, the FY09 Budget allocates \$41.9 million for State Health Insurance Assistance Program (SHIP) grants and other community-based outreach. More than 13,000 counselors in over 1,300 community-based organizations will provide one-on-one assistance to beneficiaries on complex Medicare-related topics.

In FY 2008, CMS continues to take several steps to direct and equip SHIPs to provide one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities. CMS is taking the following steps:

- In FY 2008, CMS continues to require that SHIPs submit program budgets that demonstrate that at least 5 percent of Federal SHIP funding will be directed toward one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities.

- In FY 2008, CMS expects SHIPs to build upon the activities begun in 2007 and to continue to foster local partnership efforts, including relationships with the mental health community, and to engage in outreach to better reach, inform, and assist beneficiaries with disabilities.
- In 2008, CMS plans to provide training at the 2008 SHIP Directors' Annual Conference on providing one-on-one counseling and outreach to pharmaceutical services to beneficiaries with mental disabilities. The training will provide the opportunity to share "best practices" from SHIPs, the mental health community and other partners.
- As part of the 2007 grant report process, CMS required SHIPs to describe their progress on efforts to enhance one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities as part of the mid-year reports required of all SHIPs. From these reports, counseling and outreach practices implemented by SHIPs will be shared in FY 2008 among the SHIP network via the SHIPTalk website and during training at the 2008 SHIP Directors' Annual Conference.
- In 2008, CMS plans to require SHIPs to continue to build capacity to serve the needs of dual eligible beneficiaries with mental disabilities. Mid-term narrative reports will again be a requirement of the Terms and Conditions of the SHIP grant.
- During FY 2007, SHIPs reported on the development of coalitions and training with their State and county community mental health agencies. In some instances, referral systems have been developed between the state or local SHIP and the community health network. SHIPs provide counseling and training on Medicare benefits, while community mental health providers have provided sensitivity training and referral networks for SHIPs. In 2008, SHIPs will continue their work with CMS Regional Offices to expand their mental health networks, using the SHIP-Technical Assistance Program (TAP) pilot project developed by CMS' Medicare Ombudsman as a model for network expansion.
- CMS is expanding the network of help available to SHIP Directors to include major disability organizations such as the Centers on Independent Living (NCIL) and National Spinal Cord Injury Association as they often encounter the target population and could work proactively with SHIPs. NCIL has chapters across the country and staff in those chapters to provide hands-on help to constituents.
- CMS continues to provide technical assistance to national disability organizations with a mental health component in their structure. CMS will provide these organizations and component members with information and access to the SHIP-TAP materials, helping them to understand the role of CMS' Ombudsman, and linking CMS Regional Offices to the SHIPs to proactively serve beneficiaries with mental illness.

- CMS is expanding the network of support for SHIPs to engage mental health coalitions such as the National Coalition on Mental Health and Aging. CMS is working with these organizations to distribute mental health information through their newsletters.
- CMS is leveraging faith-based programs to reach out and serve people with disabilities, including those with mental illness. CMS is exploring ways to combine outreach efforts that will have a national impact. Examples of national faith-based partners include Catholic Charities and Lutheran Services of America.
- CMS is leveraging the networks of its national partners that provide direct services to homebound beneficiaries, many of whom struggle with depression and anxiety. CMS staff will share SHIP-TAP training and contact resources with these providers of service. Examples of partners are the Visiting Nurses Association of America, the Occupational Therapy Association of America, and the Physical Therapy Association of America.

INFANT MORTALITY

Ms. Roybal-Allard: After decades of decline, there has been little progress in lowering the U.S. infant mortality rate since 2000. Your own Secretary's Advisory Committee on Infant Mortality includes some of the nation's preeminent experts and public health practitioners on this issue, and it is my understanding that they make regular recommendations for actions the Department could take to reduce infant mortality.

Many of the maternal and child health programs included in the President's budget are proposed to be flat-funded. Is this an indication that the Department of Health and Human Services does not prioritize the lowering of infant mortality rates that continue to be embarrassingly higher than virtually all other industrialized countries?

Secretary Leavitt: No, the Department is committed to lowering the rate of infant mortality and views it as a priority. The FY 2009 request continues key initiatives and efforts aimed at reducing infant mortality. Using a synergy of approaches with the Health Resources and Services Administration's (HRSA) Maternal and Child Block grant to states providing a foundation, the Department's Office of Minority Health (OMH) and HRSA's Maternal and Child Health Bureau's Healthy Start programs are spearheading efforts in this area.

In 2007, OMH launched the National Partnership for Action to End Health Disparities. This initiative includes infant mortality as a priority and is engaging communities and other stakeholders in finding solutions to address this important health concern. The Healthy Baby Begins with You Infant Mortality Awareness Campaign targets, in particular, the African American community. The campaign seeks to help organizations, health departments, offices of minority health, and the private sector to connect with each other, pool their resources, and sustain their current efforts, instead of

duplicating them. The campaign is working closely with many Healthy Start programs, health departments, community organizations, historically black colleges and universities, to promote what they have selected as their priorities for their particular communities, whether that is preconception care, low birth weight prevention, SIDS prevention, or responsible fatherhood.

The Healthy Start program is a community-driven initiative in 99 communities and 38 States. Communities have project areas with high annual rates of infant mortality in one or more disparate subpopulations: Hispanics, Native Americans, African-Americans, Asian/Pacific Islanders, and immigrant populations, etc. The program focuses on the contributing factors which research has shown influence the perinatal trends in these vulnerable high-risk communities. Funded communities have an active consortium of key stakeholders, including women and families served by the project. These stakeholders work with the consortium to implement a plan to reduce barriers, enhance the capacity of the local perinatal service system to provide quality, responsive services, and work towards eliminating existing disparities in perinatal health. With the leadership of the consortium, Healthy Start projects implement in a culturally and linguistically sensitive manner, the core service interventions of direct outreach, case management, health education, interconceptional care, and screening for depression. Over the next two to three years, Healthy Start is particularly focusing on the interconception period, working with Community Health Centers and local MCH providers to incorporate the evidenced based findings of the CDC Select Panel on Preconception Care into everyday practice of clinicians across the country in order to promote healthier women entering pregnancy and reduce the number of low birth weight infants, a major cause of infant mortality. In addition, four core system activities are required: development of local health systems action plan, a consortium, collaboration with the State Title V Program and a sustainability plan. Healthy Start is a gap filling program. If any of these interventions are already adequately provided in the project area through other funding resources, the project describes in detail why they need not provide them, and also indicates how these resources are integrated into their project.

By reducing a significant barrier to utilizing appropriate health care, Healthy Start projects have made important strides in helping at-risk mothers have healthy babies and families. Thirteen Healthy Start communities reported no infant deaths among program participants for the past four years (2002-2005): Mobile, AL; Oakland, CA; Fresno, CA; Atlanta, GA; Hawaii County, HA; Kalamazoo, MI; Louisville, KY; La Clinica de Familia, Las Cruces, NM; Brooklyn, NY; Downstate, NY (Nassau, Queens and Suffolk Counties NY); Portland, OR; Philadelphia, PA; San Antonio, TX; Fort Worth, TX; Valley Primary Care Network from Brownsville, TX. Thirty seven sites reported no infant deaths among program participants for the past year. Several sites are also reporting community level infant mortality rates for African Americans below the overall national infant mortality rates.

Ms. Roybal-Allard: What actions are the Secretary's Advisory Committee recommending to address the infant mortality issue, and when will the Department be releasing their most recent report?

Secretary Leavitt: The Secretary's Advisory Committee on Infant Mortality (SACIM) provided a number of recommendations in three separate reports including:

- Sponsor a "State-of-the Science" Conference. This multi-disciplinary conference will enhance the understanding of what is known about the determinants of the disparities in infant mortality. This knowledge base will be used to develop a strategic action plan that will help set the agenda for future research and demonstration projects and their funding.
- Convene a State-of-the-Evidence Conference to identify interventions for which there is clear evidence that they effectively reduce infant mortality. Conference participants should represent a wide range of stakeholders, public and private. Participants will also be charged to identify opportunities and barriers relating to full implementation of these evidence-based strategies and to identify successful approaches that are community-based and culturally competent.
- Focus HHS priorities, funding and services on evidence-based practices and proven strategies to improve birth outcomes and reduce infant mortality. These practices should be the standards set for clinical practice and public health care.
- Improve coordination between CMS, HRSA's Maternal and Child Health Bureau and other federal agencies to improve public health, eliminate health disparities, and coordinate maternal and child health services to reach the Healthy People 2010 goals.

Ms. Roybal-Allard: What resources will be needed to implement the opportunities they have identified?

Secretary Leavitt: There are a variety of activities that HHS is undertaking that will address the recommendations put forward by SACIM. These activities include the following:

- Surgeon General's Conference on Prevention of Preterm Birth
 - This two day conference to be held in June 2008 will focus on the following areas:
 - Biomedical Research
 - Epidemiological Research
 - Psychosocial Research
 - Professional Education and Training
 - Public Communication and Outreach
 - Quality of Care & Health Services
- CDC Select Panel on Preconception Care
 - A meeting of the Centers for Disease Control and Prevention (CDC) Select Panel on Preconception Care was held in June 2005, in conjunction with the first National Summit on Preconception Care. The Select Panel developed the Recommendations to Improve Preconception Health and Health Care, published in April 2006 in the Mortality and Morbidity Weekly Report Recommendations

and Reports. In June 2006, three workgroups of clinical, public health, and consumer experts were convened to discuss how to translate the recommendations into action. The final report of these activities can be found at the following website and include an identification of resources needed:

<http://www.cdc.gov/ncbddd/preconception/documents/Workgroup%20Proceedings%20June06.pdf>.

- Four goals were set to achieve the vision of improved health and pregnancy outcomes in the United States. They are:
 - Goal 1. To improve the knowledge, attitudes, and behaviors of men and women related to preconception health.
 - Goal 2. To ensure that all U.S. women of childbearing age receive preconception care services screening, health promotion, and interventions—that will enable them to enter pregnancy in optimal health.
 - Goal 3. To reduce risks indicated by a prior adverse pregnancy outcome through interventions in the interconception (inter-pregnancy) period that can prevent or minimize health problems for a mother and her future children.
 - Goal 4. To reduce the disparities in adverse pregnancy outcomes.
- Evidence-based clinical guidelines for consumers and providers will be released later this spring.
- The Centers for Medicare and Medicaid Services (CMS) is addressing the SACIM recommendations in a variety of ways:
 - CMS State Plan Amendments (SPA) are currently reviewed by a team of experts at both the Regional and Central Offices. Depending on the purpose of the amendment, the SPAs are reviewed by experts in coverage, quality, reimbursement, policy and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program coordinator. EPSDT services ensure Medicaid eligible children receive all medically necessary services. Medical necessity is determined by Medicaid Officials at the State level.
 - All benchmark plans are reviewed by the Central and Regional Offices to ensure compliance with federal guidelines related to the provision of EPSDT services for infants.
 - CMS has formed many partnerships in the area of maternal and child health including serving on the Preconception Health Policy Committee developed by CDC, serving as an ex-officio member of the Secretary's Committee on Infant Mortality (SACIM), developing a Neonatal Outcomes Improvement Project described in more detail below, working on a childhood obesity prevention initiatives, and working with HRSA on Health Information Technology and quality improvement activities. CMS will continue to develop strategic partnerships to improve the health of mothers and children

CMS, in partnership with the National Initiative for Children's Healthcare Quality (NICHQ), has embarked upon an exciting initiative to work with States and other partners to improve neonatal outcomes through broader adoption of proven clinical interventions. The project involves implementing nine evidence-based interventions that are known to reduce morbidity and mortality and to reduce cost. Nearly 40 percent of

the medical costs in this country related to preterm birth are paid by Medicaid. The interventions begin with the assessment of maternal risk, care of the high-risk infant in the neonatal intensive care unit when necessary, and continuity of care when returning the infant to the community. CMS funded the development of the change package and has funded one State to pilot the implementation. (Funding for this project has ended.) Many other States would like to participate in this project and require start-up support for the demonstration. Private partners such as the March of Dimes have also been approached by States to help them in these efforts.

UNACCOMPANIED ALIEN CHILDREN

Ms. Roybal-Allard: In the FY 2008 budget, in HR 110-231, the House recognized "the legal representation crisis" of unaccompanied alien children whereby the vast majority of over 10,000 unaccompanied alien children go unrepresented in their adversarial immigration proceedings. Children represented by counsel have up to an eightfold likelihood of being granted asylum than unrepresented children according to U.S. Commission for International Religious Freedom. In SR 110-117, the Senate concurred by directing the Office of Refugee Resettlement to expand the pro bono legal service initiative to include services to unaccompanied alien children both held in and when released from federal custody

How do you plan to bring your agency into compliance with this legislative directive? Given that at many facilities of over 100 children there is only a sole nonprofit attorney to screen all the children and refer and mentor pro bono attorneys in their cases, what additional pro bono services do you need to add, and what resources will you need to achieve that capacity?

Secretary Leavitt: To enhance pro bono services, the Office of Refugee Resettlement in the Administration for Children and Families plans to nearly double the amount of funds for this effort (for a total of \$5 million in FY 2008) in order to:

- Expand and enhance legal services to the areas of the country with the highest concentration of Unaccompanied Alien Children (UAC).
- Improve referral of released UAC to pro bono attorneys upon release to family and sponsors to ensure continuation of legal representation once a UAC is released to a sponsor.
- Support a national referral network that will facilitate pro bono legal representation for UAC upon their release from ORR custody, thus increasing their appearances in immigration court and their likelihood of winning immigration relief. This referral network will be centralized and provide training for legal service providers on strategies for recruitment, mentoring, and retention of pro bono attorneys.
- Extend legal orientation presentations to the UAC's sponsor(s) before releasing the UAC to that sponsor(s).

- o Improve and expand on legal orientation presentations for UAC by enhancing pro bono attorney training to include expertise in child welfare and child development, in addition to expertise in immigration law.
- o Support training for pro bono attorneys and legal service provider attorneys on T-visas, U-visas, SIJ visas, and mentoring services by legal experts in immigration law.

RURAL HEALTH

Mr. Udall: Mr. Secretary, I note that your PART rating the rural health safety net programs received a score of "adequate." The same score was awarded to Ryan White HIV/AIDS programs, for which the President has proposed an increase, and the Nursing Education loan repayment and scholarships, for which, in the past, the President has also proposed increases. There is no denying the value of those two programs, though the same should be said for rural safety net programs. I have serious doubts about this whole PART rating you use in the first place, but nevertheless, that aside, can you please explain this to me?

Secretary Leavitt: The PART rating is just one tool used for making budget decisions. The PART rating for the rural safety net programs noted that the Administration believes there is some overlap in the rural grant programs and other programs within HHS. Other programs within HHS, such as the expansion of the Community Health Center program, help meet the needs of rural communities. The President's 2009 budget recognizes the need to continue focusing on rural health by including funds for the policy and research activities of the Office of Rural Health Policy as well as for the State Office of Rural Health grant program. Additionally, while the Ryan White HIV/AIDS program received a rating of "Adequate" in its calendar year (CY) 2002 PART review, in CY 2007 the program received the highest possible rating of "Effective".

TITLE VII HEALTH PROGRAMS

Mr. Udall: Once again the Administration has eliminated funding for the Title-7 health professions programs. The Administration has maintained that its reason for not funding them is that they are "ineffective." This committee has restored some of the funding because we know they are important programs. Could you tell the Committee, when the Department seeks grant applicants for these funds, do you get more approved requests than you can fund?

Secretary Leavitt: Yes, there are more applications approved than we can fund. Appropriations received for Titles VII and VIII programs must first be utilized to fund non-competing continuations and then the remaining funds are used to support new applications.

COMMUNITY HEALTH CENTERS

Mr. Udall: Mr. Secretary, I am pleased at the continued support for the Community Health Centers Program. These centers are a critical part of New Mexico's health care infrastructure. My question relates, however, to staffing levels at the CHC's in our communities. You continue to expand CHC's, which, again, is great. However, at the same time you continue to take aim at the Title VII programs. I don't know what the case is in other states, but in New Mexico, the CHC's rely fairly heavily on health

professionals from the Title VII programs. When putting together the budget, did you give this any thought?

Secretary Leavitt: Health Center Program grantees continue to recruit and retain high quality physicians and other providers from a variety of sources. In CY 2006, Health Centers employed 7,595 physicians nationwide, an increase of 33 percent from CY 2002. Similarly, in terms of nurse practitioners, physician assistants and certified nurse midwives (NP/PA/CNM), Health Centers employed 4,292 NP/Pas/CNMs, an increase of 35 percent from CY 2002. Health Centers utilize and rely on a variety of recruiting mechanisms to assure they have access to appropriate and qualified clinicians. The FY 2009 Budget focuses on activities that directly place more physicians, dentists, nurses, mental and behavioral and other health care professionals in the regions of the country that face shortages. The budget includes an \$11 million increase for National Health Service Corp Recruitment activities and a \$13 million increase for Nursing Loan Repayment and Scholarship programs. These activities provide loan repayment and scholarships to health professionals in exchange for service in an underserved area.

Mr. Udall: Mr. Secretary, I am pleased to see continued commitment to the Community Health Centers Program. But I'd like to ask you today not on the expansion of the Health Centers program, but rather on making sure that existing centers are able to operate effectively as they provide care to our communities. Health Centers like the one in my district need funding to keep pace with the rising costs of health care, and with the rising percentages of uninsured patients many of them are seeing. With that in mind, does the President's budget request for Health Centers include money for base grant adjustments for existing centers?

Secretary Leavitt: For FY 2009, the President has proposed \$26 million for 40 New Access Points (NAPs) and 25 planning awards targeting high poverty areas. Funding for base adjustments for Health Centers is not included in the President's FY 2009 budget.

NATIONAL HEALTH SERVICE CORPS

Mr. Udall: Mr. Secretary, I think we can all say we were pleased to read in the budget that you've added roughly \$11 million to the National Health Service Corps for approximately 200 additional dentists. My concern, however, is with the cut of some \$14 million to the "field placement" section of the NHSC that is used to "offset" the cost of those new dentists. This section plays a vital role in supporting the clinicians in the field and performing outreach to get new medical students and residents into the NHSC. Can you give the Committee a better sense of why you felt if appropriate to cut from one side of the National Service Health Corps to fund another?

Secretary Leavitt: The reduction in the NHSC Field Line reflects anticipated savings from several sources. First, the NHSC has been consolidated with the Nursing Scholarship and Nursing Education Loan Repayment Programs under the Bureau of Clinician Recruitment and Service (BCRS). HRSA anticipates that by 2009 the

integration of these program's resources and functions will result in real economies of scale. Supporting and augmenting this integration will be the implementation of the new BCRS data management system which, by 2009, will enable the programs to fully operationalize on-line application and processing, improving efficiencies and reducing the current significant costs of paper reproduction and mailing. Further, the new system, which will be operated and maintained within HRSA, replaces the programs' legacy data management systems (BHCDANET and the Nursing Information System (NIS)), which currently require costly operation and management contracts to maintain. Finally, the Transformation of the USPHS Commissioned Corps is expected to progress, with more and more officers trained in emergency response and formed into deployment teams under the Office of Force Readiness and Deployment. In these circumstances, HRSA anticipates that the costs of readiness training of the NHSC Ready Responders will significantly decrease, and it will no longer be necessary to maintain the Ready Responders at the current authorized level of 55 officers as more officers in the other agencies are trained.

CDC FUNDING

Mr. Udall: Mr. Secretary, let me read some numbers and statistics. About 176,500 people aged 20 years or younger have diabetes. This represents 22% of all people in this age group. About one in every 400 to 600 children has type 1 diabetes. In 2006, only four states had a prevalence of obesity less than 20%. Twenty-two states had a prevalence equal or greater than 25%; two of these states had a prevalence of obesity equal to or great than 30%. 25.6 million adults in the general population have diagnosed heart disease. 39 percent of adults engage in no leisure-time activity. 17 percent of kids between the ages of 12 and 19 are overweight. 19 percent of kids between ages 6 and 11 are overweight. 15.7 million adults in the general population currently have asthma. 6.8 children currently have asthma. I could go on, but let me read you some numbers now from your CDC budget justification. Heart Disease and Stroke funding reduced by \$1.2 million dollars, Diabetes funding reduced by \$250 thousand dollars, Cancer Prevention and Control reduced by \$7.7 million dollars, Arthritis funding reduced by \$100 thousand dollars, Nutrition Physical Activity and Obesity funding cut by \$170 thousand dollars, Health Promotion funding cut by almost \$5 million dollars, Oral Health reduced by \$50 thousand dollars, the REACH program that addresses minority health problems reduced by almost \$10 million dollars. Please explain to me how the rationale behind decreasing the federal commitment to tackling these diseases as their prevalence continues to increase.

Secretary Leavitt: Over the past decade, CDC has developed a strong science base for our chronic disease programs. We know that effective prevention measures for chronic disease exist and that they will work. These include the use of early detection practices for cancer, diabetes, and heart disease and stroke; school health education programs, supportive environments for physical activity and healthy eating in communities, and establishment of standards for preventive care practices. For example, several clinical trials have provided evidence that type 2 diabetes can be prevented through lifestyle and behavior change. With 54 million Americans at very high risk for

developing type 2 diabetes, this nation has the opportunity to apply the current science base to significantly reduce or stop the onset of diabetes and concurrently reduce the burden of this costly chronic disease. For children born in 2000, the lifetime risk for developing diabetes is one in three. Primary prevention of diabetes must be an important priority for the nation.

The FY 2009 President's Budget Request maintains CDC's efforts in Chronic Disease Prevention and Health Promotion Programs at more than \$800 million. Through the Steps Program, local communities are implementing evidence-based interventions in community, school, workplace, and health care settings and make the critical local changes necessary to prevent chronic diseases and their risk factors. Special focus has been directed toward populations with disproportionate burden of disease and lack of preventive services. Steps communities have produced positive results, including: reducing obesity through community-based interventions, reducing chronic disease risk factors and health care costs in workplaces; creating healthier school environments including smoking bans, provision of nutritious foods, and physical activity enhancements; implementing clean indoor air ordinances; and reducing blood sugar levels among diabetes patients.

The FY 2009 Budget Request for the Steps Program is \$15.5 million, a \$9.6 million decrease from FY 2008. The Steps program is changing the grant structure in FY 2009 and anticipates funding 50 Steps Community Grants. The current funding announcement incorporates the lessons learned from the Steps demonstrations and will focus on more broadly disseminating interventions, through a redesigned program to have a greater impact on the health of our Nation's communities. Tools, resources, and training will be provided to community leaders and public health professionals to equip these entities to effectively confront the realities of the growing national crisis in obesity and other chronic diseases in their communities. In addition, lessons learned, models, and tools for local action to prevent chronic diseases will be disseminated to funded and non-funded communities to broaden the reach of the program across the nation.

CDC – TUBERCULOSIS FUNDING

Mr. Honda: The CDC Budget Justification, the decline of TB cases in the US. While this is heartening, it is not true for my county, Santa Clara. California has 20% of the nation's TB cases and Santa Clara County alone has 228 cases – more than 35 states in the union. Santa Clara County has seen a rise in the number of TB cases every year and in fact had the largest increase statewide at 14% in 2006. Santa Clara County gets only \$4,000 per case while cities like Baltimore, San Francisco, and NYC get around \$10,000 per case. How are these rates calculated and how does an area become designated a CDC Metropolitan Area for Special Attention?

Secretary Leavitt: The number of TB cases in the U.S. has declined by almost 50% since 1992, due to the successful implementation of effective TB prevention and control strategies. In California, the following MSAs have the highest number of cases of TB in 2006 (in descending order): Los Angeles, San Francisco, San Diego, and Santa Clara. Only nine large cities in the United States receive direct funding from CDC for TB control. Most large cities in the United States receive Federal funds from allocations made to them by the States. In addition to allocating Federal funds to local governments, the States (primarily public health departments) provide vital support to TB related activities including: surveillance, training, outbreak response, and medical consultation.

At present, CDC allocates 35% of its TB grant funds based on current case numbers and other factors complicating the treatment of those cases. As a result of this formula, the funds allocated to the State of California increases by slightly over \$1 million dollars in FY 2008. The allocation of those funds within the State is determined by the State.

CDC – SLEEP DISORDERS

Mr. Honda: In the 2008 omnibus appropriations bill signed by the President, Congress provided for nearly \$1 million to fund the National Sleep Roundtable with CDC. I'd like to work closely with you and the committee to build on this support for activities related to sleep and sleep disorders.

Secretary Leavitt: In FY 2008, Congress provided \$818,000 to CDC for activities related to sleep disorders including CDC's participation in the National Sleep Awareness Roundtable, a group comprised of agencies across the United States that focus on raising the visibility of the importance of sleep, and incorporating sleep and sleep-related disturbances into established CDC surveillance systems.

In response, CDC is conducting a number of activities in FY 2008 including continued participation and support for National Sleep Awareness Roundtable activities. In November 2007, CDC established a "Sleep and Sleep Disorders" Web site to begin to address public health issues related to sleep (<http://www.cdc.gov/Features/Sleep/>). The 2008 Behavioral Risk Factor Surveillance System (BRFSS) core questionnaire now includes a question on sleep that is being asked by all 50 states and the District of

Columbia (the question is “*During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?*”). This question will help assess the prevalence of sleep disturbances and better enable researchers to address the complex interrelationship widely reported between sleep and the public’s health. In addition, CDC has proposed a new optional module on sleep, which is under development for the 2009 BRFSS questionnaire.

CDC researchers also recently conducted an analysis on 2006 BRFSS data from four states which indicated that only about 1 in 3 adults (29.6 percent) reported no days of insufficient rest or sleep in the past 30-days, and 1 in 10 (10.1 percent) reported insufficient rest or sleep every day during the past month.

TITLE VII HEALTH PROGRAMS

Mr. Honda: I am glad to see that the President included an increase for Community Health Centers in the budget; I have a number of clinics in my district who serve low-income and uninsured individuals. However, I see that you have eliminated virtually all the Title VII health professions training programs – including the HCOP/COE programs, scholarships for disadvantaged students, and primary care physician training programs – in addition to cutting funding for the National Health Service Corps.

How do you reconcile the statement that your aim has been to increase access to affordable healthcare while slashing the pipeline for minority and disadvantaged students use to pursue careers in medicine?

Secretary Leavitt: In order to improve the health of the underserved, and to improve the distribution of health professionals, the budget focuses on the placement of more doctors, nurses, and other health care professionals in the regions of the country that face shortages. The Centers of Excellence (COE) Program primarily provides funds for infrastructure rather than funding students. The Health Careers Opportunity Program (HCOP) provides funds primarily for training students early in the education pipeline rather than those who are nearer to entering the health professions workforce.

CDC – VIRAL HEPATITIS FUNDING

Mr. Honda: The Division of Viral Hepatitis has been essentially flat funded for the past four years and while the incidence of acute Hepatitis cases has decreased, the number of chronic cases continues to grow. . Hepatitis B is 100 times more infectious than HIV and more than two-thirds of the 12 million Americans infected with hepatitis B have no symptoms. Those who do not receive treatment often suffer cirrhosis of the liver, liver failure and liver cancer. Hepatitis B costs our country \$700 million every year.

- a. In light of those costs to our country, I would simply like to state how gravely disappointed I am that you and the President have chosen to flat fund this

program again and urge you to commit to working with the committee to increase funding to this division in FY2009.

Secretary Leavitt: HHS remains committed to maintaining a robust portfolio of hepatitis prevention and research activities. Through the combined efforts of the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC), the FY 2009 budget provides approximately \$190 million for hepatitis related activities. CDC has issued recommendations to eliminate Hepatitis B in the U.S. as well as guidelines for prevention and control of Hepatitis A and C. The availability of effective vaccines for Hepatitis A and Hepatitis B has enabled great progress in the control of these two infections. Hepatitis A incidence has decreased by approximately 88 percent nationwide and childhood immunization and perinatal screening programs have produced similar results in regard to Hepatitis B. Targeted prevention efforts have yielded a decline of approximately 80 percent in hepatitis C incidence since the late 1980's and blood donor screening has virtually eliminated transfusion-associated cases.

The CDC and the National Institute of Diabetes, Digestive, and Kidney Research (NIDDK) continue to work together to develop national recommendations for chronic hepatitis B virus screening and care. The NIDDK also recently sponsored an initiative to establish a Hepatitis B Clinical Research Network that would promote translational research on hepatitis B. With regards to hepatitis C, several institutes at the NIH support robust clinical research, including studies investigating causes of and approaches to overcoming antiviral drug resistance. Moreover, CDC continues to investigate various screening and public education approaches, including age-based screening programs, to identify the most effective strategies for reaching populations at risk for chronic infection with hepatitis C.

FDA HIRING

Mr. Walsh: FDA's greatest strength is its people, but I am concerned about the agency's ability to sufficiently recruit and retain top scientists and medical staff. Implementation of the *Food and Drug Administration Amendments Act of 2007* is a significant Congressional priority for 2008, but successful enactment is contingent on the agency's ability to hire several hundred new scientists and medical reviewers to execute the Act's many provisions. Nonetheless, it is our understanding that HHS hiring processes can be quite cumbersome and that it often takes several months to hire a new recruit, during which time many qualified candidates accept other job offers. Given the importance of meeting the congressionally mandated FDAAA implementation milestones, what steps are you taking to cut through the red tape or circumvent Department HR processes in order to achieve targeted FDA staffing levels in a timely manner?

Secretary Leavitt: FDA senior management has also expressed concern with regard to our ability to hire the several hundreds new scientists and medical review staff that will be needed to execute the Food and Drug Administration Amendments Act's (FDAAA) many provisions. In response to those concerns, FDA, with the support of HHS, has petitioned the Office of Personnel Management (OPM) for Direct Hire Authority for the mission critical and hard-to-fill positions that will be hired to support FDAAA. The use of Direct Hire Authority will enable FDA to more expeditiously recruit the staff needed without going through the normal competitive process. While awaiting the decision from OPM on our request, we have partnered with the Human Resources Center to post open continuous vacancy announcements to begin to generate an applicant pool from which selections have already been made. FDA will be offering to many of our candidates the various types of recruitment incentives to include Student Loan Repayment, Recruitment Bonuses, and/or Service Credit for Annual Leave. FDA has also worked with HHS to request certain delegations of authority that would help in expediting the approval of certain recruitment incentives and tentative job offers. Lastly, FDA has acquired the services of a contractor to assist with marketing, recruitment events, and security processing.

MEDICARE PART D

Mr. Walsh: Secretary Leavitt, I read in a recent press release that the overall projected cost of the Part D drug benefit is \$117 billion lower over the next ten years than was estimated last summer. That decrease is on top of last year's 30 percent decrease in the program's 10 year projected cost. You also said that compared to original Medicare Modernization Act (MMA) projections, the net Medicare cost of the new drug benefit is \$244 billion (or 38 percent) lower over the ten- year period (2004-2013) used to score the MMA. CBO has also shown significant reductions in their estimated costs of the program, reducing their total 10 year estimate by 36% over the last two years. I have two questions about this.

- First, could you identify the factors responsible for these falling costs?
- Second, have you ever seen this occur in Medicare Parts A and B, which don't have the type of competition used in Part D?

Secretary Leavitt: The key factors for the \$243.7 billion difference between the original MMA projections and the President's FY2009 estimates of net Medicare cost are slower than expected growth in prescription drug costs, greater than expected savings achieved by plans, and lower than expected enrollment somewhat due to the many beneficiaries who have other sources of creditable coverage. The greater than expected savings reflects the success that plans have had with negotiating retail prices and manufacturer rebates in their efforts to offer high quality coverage to beneficiaries for the lowest possible cost.

The key factors for the \$117 billion difference between the FY2008 mid-session review and the FY2009 President's Budget estimate of net Medicare cost are higher than expected rebates, lower than expected actual 2006 Part D spending, and lower than expected growth in drug costs.

The underlying components of the prescription drug benefit program budget estimates are vastly different than those that are taken into account under the Part A and B estimates. While it is difficult to make comparisons between trends in these estimates, we appreciate the important role that competition can play throughout the Medicare program and have actively pursued initiatives that promote competition across our programs. For example, our recent efforts to implement competitive bidding for durable medical equipment are expected to save the Medicare Part B program about \$1 billion dollars annually when fully implemented. Competitive bidding provides a way to harness the marketplace to obtain a better value for Medicare beneficiaries using these items and services.

Mr. Walsh: Recently released surveys consistently report that Medicare Part D enrollees are overwhelmingly satisfied with the coverage they are receiving under the Part D program. In four separate surveys done during the fall of 2007, 83 percent to 89 percent of Part D enrollees have indicated they are either "satisfied" or "very satisfied" with their coverage. These findings come from surveys conducted by Medicare Today, the Medicare Rx Education Network, AARP, and The Wall Street Journal Online/Harris Interactive. How is the program able to achieve these rates of satisfaction?

Secretary Leavitt: Beneficiaries in the Part D program continue to enjoy excellent value and consumer choice. The actual average premium paid by beneficiaries for standard Part D coverage in 2008 is expected to be nearly 40 percent lower than originally projected when the benefit was established in 2003. Part D plans offer beneficiaries robust formularies and provide convenient access to a large network of participating pharmacies. The meaningful plan choices available to beneficiaries allow them to select a plan that best meets their particular needs and coverage preferences. Our education and support efforts, including the Medicare Plan Finder website and 1-800-MEDICARE, and the resources available through our partners such as the SHIPs,

continue to give beneficiaries the tools that they need to get the most out of their Part D choices.

Behind the high overall satisfaction ratings in the surveys cited in the question are equally high satisfaction ratings for the cost, coverage, and convenience of Part D plans. For example, the results of the 2007 Medicare Rx Education Network survey showed that beneficiaries found their plan convenient to use, were satisfied with their plan's customer service, found their co-pays and monthly premiums affordable, and were satisfied with the medications covered by their plan. Part D is working especially well for those who need assistance most urgently. The Medicare Rx Education Network showed that almost 9 out of 10 dual-eligible enrollees are satisfied with their coverage.

Mr. Walsh: Secretary Leavitt, according to CMS the Part D program provides incentives for Part D plans to use negotiated rebates from drug manufacturers to lower their bids and beneficiary premiums rather than the prices of drugs. Plans, therefore, are more likely to apply manufacturer rebates to reducing their bids, which in turn reduces beneficiary premium costs, as well as the costs of federal subsidies supported by taxpayers. And it seems to be working since both the Actuary's and CBO's estimated cost of the program continue to decline, and you've stated that the average beneficiary monthly premium in 2008 is \$25 dollars, compared with the \$41 previously projected for 2008. Could you confirm my understanding that, for the reasons I've mentioned, the drug prices posted on the Medicare Plan Finder website do not reflect all of the negotiated savings achieved by Part D plans and that there are additional savings that reach seniors and disabled persons as well as taxpayers through lower premiums.

Secretary Leavitt: Rebates from drug manufacturers to plans are typically awarded retrospectively based on utilization. For this reason, they cannot easily be passed on to beneficiaries at the point of sale. However, plans estimate their rebates in their bids for each year, and these rebates reduce the overall cost of the bid, thereby reducing enrollee premiums and the federal direct subsidy.

Mr. Walsh: On August 13, 2007, CMS announced that the 2008 "national average monthly bid," for Part D plans is \$80.52. This is just 9 cents higher than the 2007 average bid and \$11.78 lower than the 2006 average bid. Clearly it is not the plan bids that are responsible for the \$3 increase in the average premium. In fact, CMS said the premium increase is "due to certain technical factors in the law that govern the allocation of plan costs between Medicare and beneficiaries. Among the most important of these factors is the normalization of the risk-adjustment model. This model allows for higher payments to plans that have sicker enrollees and lower payments to plans that have healthier enrollees." Just to be clear, according to CMS' in-depth review of the plan bids—which increased by just 9 cents in 2008 and are \$11.78 lower than the 2006 bids—was the increase for 2008 a sign of increasing costs or of a change in the formula that's now almost fully phased in?

Secretary Leavitt: The increase from 2007 to 2008 in the Part D projected average premium due to the standard benefit is the result of two key factors. The first factor is the methodology used to calculate the national average bid, from which beneficiary premiums are derived. CMS is continuing to phase in the calculation to the full enrollment-weighted approach for calculating the national average bid amount. The result of continuing to transition each year to the weighted average approach is that the average Part D premiums increase at a faster rate than do plan bids. CMS expects to complete the transition to the full enrollment-weighted approach in 2009.

As you mentioned, the second factor is the application of a normalization factor to the risk adjustment model that is used to pay plans a higher amount for sicker enrollees and a lower amount for healthier enrollees. For risk adjustment to work properly, the average risk score of the population needs to be 1.0. Risk scores tend to increase over time, resulting in an average risk score for the population that is higher than 1.0. In order to ensure that the average risk score remains at 1.0, CMS will apply a normalization factor to adjust Part D risk scores downward. For 2008, risk scores were adjusted downward in order to achieve a 1.0 average beneficiary risk score. As a result of this adjustment, the portion of the premium paid by the government decreases and the premium paid by enrollees increases.

Mr. Walsh: Secretary Leavitt, a number of my colleagues have called for government "negotiation" of drug prices paid in the Part D program. But I've never really seen a description of how this would work, except from the Congressional Budget Office. As you know, the CBO has said "...without the authority to establish a formulary, we believe that the Secretary would not be able to encourage the use of particular drugs by Part D beneficiaries, and as a result would lack the leverage to obtain significant discounts in his negotiations with drug manufacturers." (Source: CBO letter on H.R. 4 to the Honorable John D. Dingell, January 10, 2007.) So it would help me a great deal if you could explain the mechanics of the Secretary "negotiating":

- Would you establish a formulary that would be used to determine which drugs are covered by Medicare plans and which aren't? If you don't get the price you think is the right price, does that mean the drug would be covered anyway, or would it be excluded from coverage?
- Would you establish other restrictions on coverage, such as deciding that because you couldn't get the price you wanted, a given drug would be covered only with a higher level of copay by the senior or only with prior authorization by the plan?
- If you weren't to impose any type of government restriction on coverage of a drug, what will be your leverage in negotiating a lower price?

Secretary Leavitt: As CBO and the CMS Office of the Actuaries have both noted in their recent review of H.R. 4, a bill allowing government negotiation, that government negotiations in the absence of the authority to restrict formularies are unlikely to have a

positive impact on the price of Part D drugs. Government leverage in negotiations could only be achieved through government imposed formulary restrictions or price controls. While there are currently over 25 million Medicare beneficiaries receiving drug coverage through Part D prescription drug and Medicare Advantage plans, plans negotiating prices with drug companies and pharmacies cover about 241 million people, or 80 percent of the population. Indeed, these are the same companies that negotiate on behalf of members of Congress for their prescription drugs. Given the leverage that plans currently enjoy, it is unlikely that the government could use the same negotiation tools currently used by plans, namely formulary restrictions and utilization management, to achieve greater Part D savings.

Given the high level of beneficiary satisfaction with the program, the lower than expected government and beneficiary costs of the program, and the opinion of CBO and the CMS Office of the Actuary that government negotiation may not lead to better prices, it is unclear why efforts to promote government negotiation should be pursued at this time.

Mr. Walsh: Some have suggested including a government-run plan in the Part D program. However, in its original analysis of the Medicare Prescription Drug Benefit in the MMA, CBO projected that the gross drug savings (compared to retail prices) for private, competitive “at-risk plans” would be double that of a fall-back, or government-run, plan. According to CBO, this “reflected the reduced financial incentives to control costs that such plans would have, and in part it reflected the less competitive environment in which they would operate.” Given this and the number of plans currently participating in the Part D program, do you think there is any reason to install a government-run plan into Part D?

Secretary Leavitt: There is clearly no need to install a government-run plan in the Part D program. In its third year of operation, estimated Part D costs continue to come in below original estimates, beneficiaries are very satisfied with the program, and enrollment in the Part D program continues to rise.

Independent analysts at the Congressional Budget Office and the independent Medicare actuaries agree that previous proposals to introduce government negotiations were unlikely to lead to lower Part D program costs. The Medicare Modernization Act (MMA) relies on health plans negotiating with pharmacies and manufacturers as well as managing costs through proven techniques.

Given that beneficiaries are very satisfied with their plans, it is unclear how many would be willing to switch to a Medicare-run plan and what additional benefit there would be to them. As currently structured, Part D affords beneficiaries the ability to choose the plan that best meets their needs from among a number of plan options. Adding a government-run plan alongside other Part D plans would not necessarily provide additional value to beneficiaries.

MEDICAID

Mr. Walsh: Secretary Leavitt, it is my understanding that drug coverage in Medicaid is an optional benefit, meaning that states may choose or choose not to provide it. In other words there is no legal entitlement to Medicaid drug coverage in the programs that the states administer. Is that correct?

Secretary Leavitt: That is correct. Under the Medicaid statute, prescription drug coverage is an optional benefit. Notably, all States have opted to provide prescription drug coverage to Medicaid beneficiaries.

MEDICARE PART D

Mr. Walsh: Many States have imposed severe per month script limits as low as three per month, which literally rations prescription drugs to their Medicaid beneficiaries. According to CRS, “[s]tates may also restrict the quantity of prescription drugs available to beneficiaries. Such prescribing and dispensing limits are ubiquitous. All but three states surveyed for the National Pharmaceutical Council (NPC) indicated the use of prescribing or dispensing limits.” (Source: CRS Report for Congress, “Prescription Drug Coverage under Medicaid,” updated April 16, 2007, pages 17-19.”)

Mr. Secretary, can you tell me whether or not the Medicare Part D program has such restrictions? If a Part D enrollee is unhappy with how his or her program works or the drugs that it covers, what recourse does he or she have?

Secretary Leavitt: Our formulary guidance strives to ensure that beneficiaries have access to a preferred drug for virtually all diseases. Plans may apply utilization management tools such as prior authorization, step therapy, and quantity restrictions in a manner that is consistent with formulary management best practices. In general, proposed utilization management practices such as prior authorization and quantity limit restrictions must be consistent with FDA label restrictions and indications. Step therapy is only permitted when the preferred treatment has an FDA approved indication for a particular condition.

All plans must establish a pharmacy and therapeutics (P&T) committee, a group of physicians and pharmacists with expertise in a broad range of specialties relevant to the Medicare population. The P&T committees are charged with reviewing clinical appropriateness of each plan’s utilization management policies to help ensure that plans are compliant with Part D’s requirements.

Beneficiaries can request an appeal on any utilization management practice. The Part D appeals process provides formal recourse to beneficiaries to request exceptions to utilization restrictions in cases where following such restriction may adversely affect their treatment. Further, we encourage all beneficiaries to periodically assess their plan choices during our open enrollment and select the plan that best meets their coverage needs.

Mr. Walsh: Mr. Secretary, Part D plans negotiate discounts and rebates for millions of seniors and disabled persons who previously paid lacked prescription drug insurance, had no one negotiating for cost savings on their behalf, and paid full retail prices for their drugs at the pharmacy. Now these beneficiaries have access to prescription drug coverage through Part D. Has HHS calculated the savings resulting from this movement of millions of seniors and disabled persons from full retail prices to negotiated prices that are lowered with discounts and rebates?

Secretary Leavitt: The Department of Health and Human Services (HHS) has not conducted a study of the savings due to the movement from full retail prices to negotiated prices under Part D at this point in time. However, plans are negotiating significant savings on the enrollees' behalf and the benefit as a whole saved beneficiaries an average of \$1,200 in 2007.

DENTAL HEALTH

Mr. Simpson: The Committee increased the funding in FY 2008 for the Dental Health Improvement Act from \$2M to \$5M. The \$2M covered grants for 18 state projects. Originally, 36 states applied for the funding. Could you tell the committee how your department plans to disperse the new grant money?

Secretary Leavitt: HRSA is preparing a new competition for the FY 2008 additional appropriations of \$3 million for Grants to States to Support Oral Health Workforce Activities. This competition will be open to all States, including those that applied in FY 2006 and were not funded. The funding opportunity is planned for release by the end of April and the awards will be made prior to the end of FY 2008.

TITLE VII HEALTH PROFESSIONS

Mr. Simpson: Last year, the Committee designated \$10M for the general practice and pediatric dental residencies programs under Title-7 health professions. Can you tell the committee how many how many applicants there were, how many requests were approved and how many were funded?

Secretary Leavitt: In FY 2007, 40 grant applications were received for the general practice dentistry and pediatric dental residency programs. Of those applicants, 34 were approved for funding and 28 were funded. The dental residency training grant awards totaled \$10,272,394.

NIH OPEN ACCESS

Mr. Simpson: Mr. Secretary, the language in the 2008 appropriations bill concerning Open Access – which mandates that researchers submit their manuscripts to an NIH database 12 months after being published – requires NIH to comply with existing copyright law. What steps is the department taking to be sure that the program is being implemented within copyright law? Is it the department's intention to follow the regular rulemaking process – with a public comment period – as part of the implementation of the Open Access provision?

Secretary Leavitt: NIH implemented Division G, Title II, Section 218 of Public Law 110-161 on January 11, 2008 (<http://grants.nih.gov/grants/guide/notice-files/NOT-OD-08-033.html>). As of April 7, 2008, applicable manuscripts arising from NIH funds must be submitted to PubMed Central (PMC) upon acceptance for publication. As of May 25, 2008, NIH applications, proposals, and progress reports must include the PMC reference number when citing a manuscript that falls under the policy. NIH has developed a website (<http://publicaccess.nih.gov/>) with training materials and frequently asked questions. In addition, NIH is in the midst of a communications effort that includes in-person trainings, news articles, and other outreach efforts. Finally, NIH is seeking formal comment on the Public Access Policy and its implementation, including ensuring that it continues to be consistent with copyright law. It is holding an open meeting for

stakeholders on March 20, 2008, and will issue a 60-day Request for Information later in March 2008. All comments collected will be publicly available at <http://publicaccess.nih.gov/comments.htm>.

Mr. Simpson: Mr. Secretary, I notice that the President's 2009 budget does not include the Open Access language – why is that?

Secretary Leavitt: We continue to fully support open and timely dissemination of scientific knowledge produced with taxpayer resources. We are working to ensure we fully implement the law and look forward to working with Congress on this issue. We understand there may be some concerns from some stakeholders about the implementation, so we are actively seeking stakeholder input. We will have a final report at the end of September.

ANTRAX VACCINE AND STRATEGIC NATIONAL STOCKPILE

Mr. Simpson: Mr. Secretary, I have had numerous meetings with your staff regarding our nation's bio-defense program and strategic national stockpile. During those meetings, we have discussed the importance of filling the stockpile. While I recognize the value of seeking out next-generation vaccines, we should also make sure that the United States has a reliable source of FDA-approved vaccines and antibiotics in case our country does face a biological attack in the future. On that note, I believe that we both recognize the importance of maintaining a reliable, dependable, domestic supply of biodefense vaccines in our stockpile and the importance of filling the stockpile to ensure that we are prepared in a time of emergency. I know that HHS has experienced numerous complications in trying to obtain sufficient supply of particularly the anthrax vaccine to fill the stockpile. Does HHS have a plan to obtain sufficient doses of anthrax vaccine for the stockpile? To follow up on that, do you have a plan to ensure that there is sufficient domestic production of key vaccines and therapeutics to maintain our Strategic National Stockpile?

Secretary Leavitt: HHS remains committed to the pursuit of the acquisition of sufficient anthrax vaccine to protect 25 million people. Our current acquisition strategy maintains that the portfolio for anthrax vaccines will be balanced in order to mitigate risk, maximize coordination with DOD, promote competition, maximize available resources, and improve overall preparedness. The portfolio is designed to include diversification of our industrial base (multiple manufacturers) and technology (both current and next-generation products). We have committed to the acquisition of nearly 30 million doses of the first generation Anthrax Vaccine Adsorbed, AVA, and have approximately 16 million doses in the SNS. We also remain committed to the development and acquisition of next-generation anthrax vaccines and will release an RFP for up to 25 million doses per manufacturer of a recombinant Protective Antigen (rPA) anthrax vaccine in March. HHS will evaluate acceptable proposals for best value and plans one or more awards subject to the availability of funds.

HHS takes a comprehensive, multifaceted approach to medical countermeasure development and acquisition. The Department works diligently (a) to obtain the most effective medical countermeasures currently available, for current and near-term needs; (b) to support advanced development of new products that will be the most effective in addressing our requirements in the future, as current supplies expire and as science, medicine, and technology advance; and (c) to seek the most appropriate medical countermeasures to address our requirements wherever they can be obtained, both for current supplies and for future development, with due regard for the integrity, security, and reliability of the source.

Consistent with Source Selection Process requirements under section 15.101-1 of the Federal Acquisition Regulation, the USG reserves the right to make an award to that Offeror whose proposal provides the best overall value to the USG whether foreign or domestic. RFPs and evaluation factors are structured to provide for full and open competition, while ensuring the government's requirements are met.

PANDEMIC INFLUENZA

Mr. Simpson: Mr. Secretary, first let me commend you for the great steps you have taken to put in place all the key elements of the National Strategy on Pandemic Influenza (NSPI). In your budget is a request for the third year of funding to complete the plan. One of the key parts of that plan is that in addition to Federal stockpiles of key medicines and supplies, we also need states to act to establish their own stockpiles. For the stockpile of antiviral drugs in particular, the national plan calls for enough to treat 25% of the population and to reach that goal, States have to act. It is my understanding that to date, the Federal government has purchased the 50 million courses of treatment as recommended under the NSPI, while the States have stockpiled only approximately 19 million of the 31 million courses of antiviral drugs called for in the NSPI. Some states have completed their stockpiles, some states are partially done and others have yet to act. My own state of Idaho has only purchased 6 percent of its antiviral allocation and is not likely to purchase anymore this year.

- What can we do to make sure all states act? Is there a deadline by which states must order their antiviral allocation before they risk losing access to the Federal subsidy?
- If even a couple of states refuse to act in advance of a pandemic, the U.S. will never reach its national goal of stockpiling enough antiviral drugs for 25 percent of the population. How do you plan to address the shortfall?
- Is there funding in the 2009 budget to address the shortfall?
- Congress has already appropriated funds for the state purchases, and HHS has set them aside for this purpose. If the states don't act, how would those funds be used?

Secretary Leavitt: The national pandemic influenza antiviral drug stockpiling goal is 81 million treatment courses with 6 million designated for early containment usage at pandemic onset and 75 million treatment courses for treatment of infected persons. As of February 22, 2008, forty-five States and other entities have procured 21.7 million treatment courses of influenza antiviral drugs. Only six States do not intend to use their Federal subsidy allocation. The present deadline for States to utilize their Federal subsidies to purchase antiviral drugs for pandemic stockpiles is July 31, 2008. By the end of March 2008, HHS will complete communications with those States that have not fully used their Federal subsidy allocations to determine the status of their commitments. Subsequently HHS will appraise the State antiviral drug stockpile program and determine the next steps. The FY 2009 request does not include funding for the Federally-subsidized State purchase of antiviral drugs.

Major issues preventing some States from purchasing influenza antiviral drugs were the expiration dating and shelf life extension of these products. Recently the FDA accepted the product claim by Roche for Tamiflu® to increase expiration dating from five to seven years; the new expiration dating would apply to both Federal and State pandemic stockpiles of this product. Coordination between the manufacturer, FDA, States, and third party companies is underway for the re-labeling of the product already in State stockpiles. The issue of States not being able to use the pandemic antiviral stockpiles purchased off of the Federally-subsidized contract for severe seasonal influenza outbreaks has also been a factor. New Mexico has solved this problem by purchasing the antiviral drugs directly from the manufacturer at price greater than the Federal contract price but considerably less than retail prices. Their stockpile has the added flexibility to address both seasonal and pandemic influenza outbreaks as well as for treatment and post-exposure prophylactic usage.

Currently HHS has obligated approximately \$90 million of the \$170 million appropriated for Federal subsidies to State antiviral drug stockpiling. HHS will obligate the remainder of these funds over the next six months as orders by States using the Federal antiviral drug contracts emerge. Decisions on remaining funds, if any, will be part of the next steps process described above.

Like other States, Idaho will receive its *pro rata* allotment of influenza antiviral drugs from the Strategic National Stockpile at the onset of an influenza pandemic. To date, twenty-three States have completed their full purchase. States which have not completed their stockpiling of antiviral drugs have until July 2008 to utilize their full allotment of Federal subsidies and Federal contracts with antiviral drug manufacturers to procure these drugs at significant savings. Afterwards States may continue to purchase these antiviral drugs for their pandemic antiviral drug stockpiles using their own contracts with the manufacturers.

Pandemic preparedness is a shared responsibility, that the Federal government cannot shoulder the entire burden, and that States, local government, businesses and families must themselves become fully prepared.

PANDEMIC INFLUENZA

Mr. Lewis: Congress and this Committee have made a significant investment preparing for a potential flu pandemic by appropriating \$5.6 billion in emergency funding to date. I understand tremendous progress has been made in developing vaccine lines and infrastructure, but that much work remains. Last year Congress did not fund the additional \$870 million requested for pandemic flu in the Omnibus, and one reason that has been cited is the remaining \$1.2 billion in funds that have not been obligated. Can you tell the committee what is happening with those dollars, and what additional funds if any are needed beyond the \$507 million in the FY09 budget request?

Secretary Leavitt: We have made enormous progress to better prepare the nation for an influenza pandemic and have obligated over \$4.3 billion out of the \$5.6 billion Congress provided in emergency funding in FY 2006.

Emergency supplemental funds totaling \$5.6 billion are being used to support expanded vaccine production capacity, and pre-pandemic vaccine purchase; antiviral purchase, including subsidizing State purchases; countermeasure advanced development; purchase of masks, ventilators, and other personal protective equipment for the Strategic National Stockpile; rapid diagnostic tests; State and local preparedness; domestic and international pandemic preparedness and response capabilities; and other preparedness activities within the Office of the Secretary and at CDC, FDA, and NIH.

HHS has plans and commitments for the entire balance of \$1.2 billion in unobligated pandemic influenza funds for ongoing milestone-driven contracts. Plans for the unobligated balances include:

Vaccines: \$959 million remains unobligated for the purchase of pre-pandemic vaccine, for cell-based vaccine projects, for the retrofitting of facilities for the emergency production of influenza vaccine, and for the advanced development of antigen-sparing techniques for influenza vaccines. HHS expects to award the majority of these dollars by the end of this fiscal year.

Antiviral Drugs: \$145 million remains unobligated for the advanced development of antiviral drugs and for ongoing State purchases of Federally-subsidized antiviral drugs. ASPR expects to award the advanced development dollars by the fourth quarter of FY 2008, and expects that States will complete their antiviral drug purchases by late summer of 2008.

Other Domestic and International Activities: \$120 million remains unobligated for domestic activities, including risk communications and the development of rapid tests. HHS expects to award the majority of these dollars by the end of this fiscal year.

State and Local Preparedness: \$24 million remains unobligated for State and local competitive grants. HHS expects to issue awards this April.

The FY 2008 Appropriations bill did not include the \$870 million requested by the President for the next phase of the HHS Pandemic Influenza Plan. This funding is intended to uphold HHS' funding commitments for additional obligations. HHS still needs the \$870 million requested in FY 2008 to achieve the goals in the President's plan. The Administration is considering options for this funding and will reach out to Congress soon.

The FY 2009 pandemic influenza request of \$507 million keeps HHS on track to meet the goals of the President's Pandemic Influenza Preparedness Plan. The request includes no-year funds totaling \$507 million to support the continued building of vaccine production capacity and the purchase of medical countermeasures and personal protective equipment for HHS employee and patient populations.

The FY 2008 and FY 2009 funding is still needed to make progress in meeting the objectives of the President's plan. These requests bring us closer to achieving our goals, while embarking on a policy of shared responsibility with our Federal, State and local partners.

AVIAN FLU

Mr. Lewis: We have heard less in the media about the threat of pandemic flu over the past year, but outbreaks of H5N1 in birds continue throughout the world, and human cases continue to be identified. Most recently (February 13, 2008), the World Health Organization (WHO) has been investigating a possible human-to-human transmission of bird flu between an Indonesian woman and her 14 year old daughter. Cases of possible human-to-human transmission are watched closely because they increase the chance of the virus mutating into a form that is easily passed between humans, which could possibly trigger a global pandemic. Are human to human transmissions of the disease still occurring in countries other than Indonesia? Where have there been recent outbreaks? What is the status of pandemic influenza globally?

Secretary Leavitt: CDC does not have comprehensive data on the source of infection for all confirmed human H5N1 cases reported in 14 countries to the World Health Organization (WHO), nor does WHO. Such information depends upon the comprehensiveness of field investigations conducted for each H5N1 case, available data, and whether such data are made available by each country's Ministry of Health. CDC staff has been involved in field investigations of some confirmed H5N1 cases in Vietnam, Turkey, Nigeria, Djibouti, Laos, Egypt, Pakistan, Thailand and Indonesia.

The majority of human H5N1 cases worldwide are believed to have acquired H5N1 virus infection from direct contact with sick or dead poultry. In some cases, the source of H5N1 virus infection is unknown. Other instances of probable, limited, non-sustained human-to-human transmission of H5N1 viruses are believed to have occurred or could not be excluded for a small number of cases in Thailand, Vietnam, Pakistan (One confirmed case reported to date), China, and Indonesia under certain circumstances,

including very close, prolonged, unprotected contact with a severely ill H5N1 patient at home or in a hospital, primarily in blood related family members.

There is no definitive laboratory test to confirm human-to-human transmission of H5N1 viruses, so this assessment relies on rapid and comprehensive field investigation. Many challenges and limitations are inherent in such assessments. Improved case investigation capacity through the training and deployment of rapid response teams in high risk countries, and the increased availability of laboratory confirmation of cases has and will enhance the ability for countries to conduct field investigations and assess whether human to human spread has occurred.

The World Health Organization (WHO) has reported avian influenza A (H5N1) human infections since January 1, 2008 in the following countries: China, Egypt, Indonesia, and Vietnam – a total of 24 cases, with 19 deaths (a case fatality rate of 79 percent). WHO reported human infections in the following countries in 2007: Cambodia, China, Egypt, Indonesia, Laos, Myanmar, Nigeria, Pakistan and Vietnam. Human cases in 2007 totaled 86, with 59 deaths (a case fatality rate of about 69 percent).

The World Organization for Animal Health (OIE) has reported animal outbreaks of avian influenza (A) H5N1 viruses in 22 countries from January 2 – March 14, 2008. The OIE reported animal outbreaks in 28 countries during 2007. The OIE also reported animal outbreaks of avian influenza (A) H7N3 in two countries in 2007. Animal outbreaks of H5N1 infection are widespread in parts of Asia, and have also have occurred in the Middle East, Africa, and Europe. More than 60 countries have been affected. (http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm, accessed 3.18.08)

There currently is no human influenza pandemic. A pandemic is a global disease outbreak. An influenza pandemic occurs when a new influenza virus emerges for which people have little or no immunity, the virus spreads easily from person to person, and causes serious illness. Influenza pandemic viruses can sweep across the country and around the world in very short time. (<http://www.pandemicflu.gov/general/index.html>, accessed 3.18.08)

With regard to the avian influenza (A) H5N1 virus, it is a new influenza virus for which people have little or no immunity. However, epidemiological surveillance and laboratory research indicate that the disease does not spread easily from person-to-person at this time.

As of March 18, 2008, the World Health Organization has reported 373 human cases of avian influenza A (H5N1) since November 2003. These have occurred in 14 countries and have resulted in 236 reported deaths (a case fatality rate of about 63 percent). Countries in which these cases have occurred are as follows: Azerbaijan, Cambodia, China, Djibouti, Egypt, Indonesia, Iraq, Laos, Myanmar, Nigeria, Pakistan, Thailand, Turkey, and Vietnam. (http://www.who.int/csr/disease/avian_influenza/country/cases_table_2008_02_28/en/index.html, accessed 3.18.08)

STRATEGIC NATIONAL STOCKPILE

Mr. Lewis: What progress has been made in stockpiling countermeasures beyond vaccines and tamiflu? For example respirators and masks, this could be our first line of protection if a viable vaccine isn't ready in time.

Secretary Leavitt: As of February 2008, the Strategic National Stockpile has a total of 39.8 million treatment regimens of Tamiflu (oseltamivir), 9.9 million regimens of Relenza (zanamivir), 105.8 million N95 respirators, and 51.8 million surgical masks on hand. The SNS also has ventilators and regimens of antibiotics that may be used to support a pandemic emergency as well as any biological, chemical, radiological or natural event.

Orders for the following items have also been placed: 6.7 million face shields, 6.2 million gowns, 17.4 million pairs of gloves, 71,000 regimens (10-days) of vancomycin (IV) for secondary influenza infections, 131,000 regimens (10-days) of levofloxacin (IV) for secondary influenza infections. Additional ventilator procurements are also underway.

FLU VACCINE

Mr. Lewis: What are the public health implications of the decreasing uptake of the seasonal influenza flu vaccine? What is HHS doing to increase uptake of the vaccine? How will the funds allocated in the HHS budget specifically address this problem? What are the implications for domestic manufacturing of vaccine if uptake of influenza vaccine does not increase?

Secretary Leavitt: During the past decade, vaccination coverage levels among adults have increased steadily. Influenza vaccination coverage levels among persons 65 years of age and older have increased from 30 percent in 1989 to 69 percent in the second quarter of 2007. Although for some time data suggested that influenza vaccination levels may have reached a plateau, the increase in coverage to 69 percent in 2007 is encouraging. Influenza vaccination coverage levels among non-institutionalized high-risk adults ages 18 to 64 years have also increased from 26 percent in 1998 to 34 percent in 2006.

During the past decade, vaccination coverage levels among adults increased steadily as HHS implemented national strategies, such as encouraging the greater use of preventive services by health-care providers and enhancing delivery and administration of vaccine by various health-care provider types. HHS worked to inform health-care providers about Medicare reimbursement for influenza vaccination, expanding vaccination recommendations for adult populations, and promoting adult and adolescent immunization among healthcare providers and state and local governments. HHS and partners such as the National Influenza Vaccine Summit will continue to aggressively promote vaccination. Health care provider recommendations for vaccination are very influential in an adult's decision to receive influenza vaccine. HHS, along with the

National Influenza Vaccine Summit, will target educational and communication efforts to health care providers. These efforts will include encouraging healthcare providers to recommend influenza vaccine to their patients and encouraging vaccination of healthcare providers, a recommended group with consistently low vaccine coverage. Efforts will also be focused on eliminating disparities in coverage.

HHS continues to work with partners to support state health departments in developing comprehensive plans for vaccination of adults; assuring pandemic preparedness efforts provide lasting benefit on immunization capacity; addressing and eliminating persistent racial and ethnic disparities in adult immunization coverage levels; developing, evaluating, and promoting standing orders and patient/provider reminder systems; and improving physician and institutional practices that lead to increased vaccination coverage among adults. The HHS Task Force to increase Health Care Worker Influenza Vaccination is working to identify and implement strategies to increase influenza vaccination in health care workers. The National Influenza Vaccine Summit is co-sponsored by the American Medical Association and the CDC. The Summit is an action-oriented entity with over 400 members who represent over 100 public and private organizations with an interest in addressing influenza and influenza vaccine issues. Summit participants include healthcare professionals, public health professionals, vaccine manufacturers and distributors, consumers, and others interested in preventing vaccine-preventable diseases.

In FY 2008, CDC was appropriated funding to increase demand for influenza vaccine. CDC is working to increase the demand for and uptake of annual influenza vaccine, particularly to accommodate high risk populations assessed by the adult immunization process measures and to implement the new ACIP recommendation for vaccination of all school aged children. On October 24, 2007, the ACIP recommended expanding the use of the nasal influenza vaccine LAIV (FluMist®) to include healthy children ages 2-4 years old (24-59 months old) without a history of asthma or recurrent wheezing. The vaccine continues to be recommended for healthy people ages 5-49 years who are not pregnant. "Healthy" indicates people who do not have an underlying medical condition that predisposes them to influenza complications.

Some of the activities awardees will be conducting with this funding include collaborating with community-based organizations to identify, refer and follow up with high risk adults in need of immunizations, encourage collaborations between public clinics and community organizations for outreach purposes, and enhance interactions with and support of adult coalitions. Grantees are encouraged to work with partners to implement strategies to improve influenza vaccination of health-care personnel, implement strategies to improve influenza and pneumococcal vaccination of Medicare beneficiaries, and implement strategies to ensure influenza, pneumococcal polysaccharide and Td/Tdap vaccination of hospitalized adults prior to discharge, and implement Joint Commission standards that establish annual influenza vaccination programs.

To ensure immunization services are readily accessible to high risk adults, grantees should work with partners for after hours immunization services, co-locate

public immunization services with other public health or social service agencies, public clinics or treatment centers that serve persons likely to be high risk, and collaborate with other local, state and Federal agencies to identify, refer and follow up high risk adults in need of immunization. With a strategy that will improve prevention of and response to seasonal influenza, increasing vaccine coverage among adults is fundamental to pandemic preparedness efforts. To the extent possible, immunization grantees are encouraged to use 317 funds for seasonal influenza and other adult vaccination activities.

The number of domestic influenza vaccine manufacturers has grown from three in 2004 to six in 2008. HHS has established a domestic influenza vaccine manufacturing capacity of 130-150 million doses per year and is working to expand capacity to 250 million doses per year by 2010. HHS is working to establish new vaccine manufacturing facilities by 2011 to produce modern cell-based influenza vaccines. This will increase domestic capacity enough to provide pandemic influenza vaccine for the entire country within six months on the onset of an influenza pandemic. Manufacturers are mitigating overbuilding capacity in the U.S. for seasonal influenza vaccines through the development of antigen-sparing adjuvants for pandemic influenza vaccines. The introduction of pre-pandemic influenza vaccines in 2004-05 represents a new product for manufacturers. The production of these vaccines has utilized 33% of the manufacturers' capacity each year and represents another means to sustain both seasonal influenza vaccines needs for public health and industry and pandemic preparedness needs for expanded domestic pandemic vaccine manufacturing capacities.

WEDNESDAY, MARCH 5, 2008.

HEALTH ISSUES AND OPPORTUNITIES

WITNESSES

ELIAS A. ZERHOUNI, M.D., DIRECTOR, NATIONAL INSTITUTES OF HEALTH

JULIE L. GERBERDING, M.D., M.P.H., DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

TERRY L. CLINE, PH.D., ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CAROLYN CLANCY, M.D., DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Mr. OBEY. Well, good afternoon, everyone.

This morning, we held a very interesting hearing. We had a variety of panelists talking to us about what this Committee should be doing by way of strengthening programs within the jurisdiction of this Subcommittee to prepare for what I believe to be the reality that the next President is going to have no choice but to deal with the issue of universal health coverage. It would be kind of nice if we were ready for that, and it would be kind of nice if we were spending money on things that actually worked especially since a lot of that money is going to be the taxpayers'.

We also talked about the fact that so often in appropriations hearings we talk in dollar terms rather than human terms, and when we do talk in dollar terms we usually talk in terms of what it costs to do A, B or C or D in any given field. But what we also need to do is to balance that off by asking what does it cost us not to do certain things. And so, that is what I would hope our witnesses could focus on and remind us of today.

For instance, doctors, when we had the meeting in the Speaker's office earlier this year, I used the example of Lou Gehrig's disease. We know that the Country spends a little over \$40 million, it has been estimated, to try to understand that disease. But we have, what, 30,000 people who are afflicted with that disease, and it costs us many times that amount in lost wages, in medical treatment, et cetera, et cetera.

So I think we would be more inclined to invest more money in some of these research efforts, in some of the public health efforts and a number of other areas if we gave as much attention to what it costs us not to proceed as it does to proceed.

I think my attitude toward the Administration's healthcare budget this year is well known. I have minimum high regard for it, to put it politely. Nonetheless, the budget is here.

The Administration has submitted a budget that freezes all funding for biomedical science, spends \$475 million less than last year

on critical public health promotion and disease prevention programs at CDC, cuts funding for healthcare outcomes and effectiveness research below last year's level, and cuts funding for substance abuse and mental health treatment and prevention activities.

I think we need to face squarely what these programs cost us, but I also think we need to face squarely what the consequence of inadequate attention to these problems winds up being for the Country, and that is what I hope we can cover today. So I will happy to call upon the witnesses for whatever comments they want to make after I have asked Mr. Walsh for whatever comments he might have.

Mr. WALSH. Mr. Chairman, we have a lot of witnesses before us. I think I will just allow them to go ahead and proceed and hopefully have some questions afterward. But thank you for holding this hearing, and we welcome the witnesses.

OPENING STATEMENT

Mr. OBEY. All right. We have with us Dr. Elias Zerhouni, Director of the National Institutes of Health; Dr. Julie Gerberding, Director, Centers for Disease Control and Prevention; Dr. Terry Cline, Administrator, Substance Abuse and Mental Health Services Administration; and Dr. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality.

Dr. Zerhouni, why don't we begin with you? Did you bring your musical instrument?

Dr. ZERHOUNI. Thank you, Mr. Chairman.

Mr. OBEY. You are not going to answer that question? [Laughter.]

Dr. ZERHOUNI. I am sorry.

Mr. OBEY. You didn't bring it?

Dr. ZERHOUNI. I was trying to avoid answering it because I think that instrument would be the focus of attention instead of the NIH.

I thought it was a great opportunity to come in front of you and members of the Committee to explain, the overall strategy of the NIH and focus my comments on the highlights of the testimony we have submitted for the record. I've identified four essential points that I think need to be understood to see where medicine and discovery and healthcare need to go over the next few years.

The first point I would like to make is the investment of the American people in the NIH has paid dividends that are difficult to overstate. The reduction in mortality of heart disease alone by 70 percent and stroke by 70 percent has allowed an economic return that is much greater than the spending that we incurred in terms of researching heart disease.

I think we have made progress on many fronts to the point where acute diseases that were short-term and lethal in the past are no longer the main challenge. The main challenge has become chronic diseases, and chronic diseases represent 75 percent of our expenditures.

It is clear that this rise of cost in healthcare is unsustainable. No one today believes that there is a straightforward strategy to sustain these costs over time. No one believes that what we have

done in the past and the strategies we have followed in the past are going to be effective in the future.

As Einstein said, a bad scientist is a scientist who keeps trying the same thing, hoping for different results. We have to change our strategies.

The challenge in front of us, obviously, is that in the past, a certain paradigm of healthcare was to strike the disease once it had struck the patient—waiting for the disease to really appear before we did anything. This sort of late reactive episodic type of care is no longer what will be needed in the future to manage chronic diseases.

We will have to be more proactive and this is what we call the new era, whereby the research we do enables us to understand disease at its beginning before it strikes the patient. We call this the four Ps of modern medicine.

We need to be more predictive. We need to find the markers, whether it be genetic markers or other markers that identify the risk of an individual.

We need to understand the environment.

We need to understand how to prevent disease. In many cases, we may not be able to do so but we need to continue our efforts to find ways of delaying the onset of the disease or reducing its complications and continue to do the research needed to alleviate the suffering of millions of patients who currently suffer from these diseases.

So the landscape of disease has changed. Our strategies have to change, and those strategies have to be a lot more proactive, more prospective than they have been in the past.

The NIH will continue to do the research we do today but also expand into new areas of science, areas of science that will allow us to understand not just at the atomic level or molecular level but also at the cellular level, the tissue level, the organ level, the mind and body level, all of the components that lead one from a healthy life, healthy status to an unhealthy status. Therefore, the scope of our research has grown.

Last but not least, I would like to say that life sciences are going to be the critical challenge of this century for any nation, just like physical sciences were in the past century. Those who develop the knowledge to overcome the challenge of rising healthcare costs and find a way of not just improving how they deliver care but what care is being delivered are going to be the nations that will sustain their competitiveness.

This will require us to focus, which is my last point, on the next generation of scientists. Nothing keeps me awake at night more than the fate of early career scientists who get discouraged from entering science at a time when the Nation needs more scientists, more engineers from all walks of science to be able to meet those challenges.

Our budget reflects these priorities. We try to maintain a number of investigator-initiated grants. We try to create programs that encourage early career scientists to remain in science to the greatest extent possible.

Those are the comments I wanted to make to highlight the priorities that the Agency has at this point. I will relinquish the rest of my time for questions.
[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Health Issues and Opportunities at NIH

Witness appearing before the
House Subcommittee on Labor-HHS-Education Appropriations

Elias A. Zerhouni, M.D.
Director, NIH

Accompanied by:

Richard Turman
Deputy Assistant Secretary, Budget

March 5, 2008

Good afternoon, Mr. Chairman, and distinguished Members of the Subcommittee. It is an honor and a privilege to appear before you today to present the National Institutes of Health (NIH) budget request and to discuss the priorities of NIH for this year and beyond.

Research is the basis of virtually every improvement in health and medicine. The impact of scientific research, however, extends far beyond disease. Throughout history, advances in science and technology strengthened our economy, raised our standard of living, enhanced our global leadership, and lengthened and improved our lives.

But to sustain these achievements, the flow of new scientific knowledge must be both continuous and substantive. Despite monumental progress, science remains a difficult frontier to explore. In this century, our society faces even greater challenges to the human condition that will require innovative and unprecedented scientific and technological advances across all fields of science, but most particularly in the life sciences. NIH's investment of \$29.5 billion in FY 2009 will be used to support such advances.

NIH plays a significant role in the extension of life and the prevention and treatment of many diseases, transforming modern research and medicine in countless ways. For example, not long ago, acute, short-term and lethal conditions such as heart attacks, stroke, acute infections and cancers were the dominant causes of early mortality. Today, life expectancy has markedly increased due to progress made in reducing death from such acute conditions. However, these advances indirectly led to a major rise in the burden of chronic long-term conditions. It is estimated 75% of today's healthcare expenditures relate to chronic diseases. The emergence and consequences of chronic conditions -- like obesity, diabetes, or Alzheimer's disease -- are examples of the challenges we face. Healthcare costs are rising exponentially. We must continue our focus on not only *how* we best deliver healthcare, but more importantly, *what* healthcare we deliver.

A New Strategic Vision for Medicine

Given this dramatic shift from acute to chronic disease, the strategies for preventing and treating diseases are beginning to shift. Today, we intervene late, when the patient exhibits symptoms of disease. Our research is changing this approach, so that we may intervene much earlier in the natural cycle of diseases, years before they strike their victims. We must now develop a much more preemptive approach that manages disease over its entire life cycle, from identifying an individual's susceptibility to a disease, to prevention, early diagnosis, reduction of complications, and smarter therapies.

This shift from a late curative paradigm to an early preemptive one is becoming increasingly possible, thanks to the avalanche of recent discoveries funded by NIH. For example, in 2002, when I became NIH Director, we knew of one important gene abnormality in type 2 diabetes. In the last year alone, researchers uncovered 7 new genes or genetic regions that provide new clues to how this disease may develop. Remarkably, I now receive about one report a week of a significant discovery in the field of genomics. Recent discoveries apply to a broad spectrum of chronic diseases, ranging from mental disorders to autism. We now can see a clear path to what we call "the 4 P's of Medicine": medicine that will be more Predictive, Personalized, Preemptive, and Participatory.

To reach these key long-term goals, NIH is strategically investing in research to further our understanding of the fundamental causes of diseases at their earliest molecular stages. But individuals respond differently to environmental conditions, according to their genetic endowment and their own behavior. In the future, research will allow us to *predict* how, when, and in whom a disease will develop. We can envision a time when we will be able to precisely target treatment on a *personalized* basis to those who need it, avoiding treatment to those who do not. Ultimately, this individualized approach will allow us to *preempt* disease before it occurs, utilizing the *participation* of individuals, communities, and healthcare providers in a proactive fashion, as early as possible, and throughout the natural cycle of a disease process.

This prospective management approach to disease is vital to the transformation of medicine of tomorrow. Today's discoveries are paving the way to make this future a reality. NIH continues its research efforts to search for cures to alleviate the suffering of the millions already affected by disease—and is greatly expanding the scope of research to discover entirely novel ways to stop disease in its tracks before it cripples us. This entails investing in completely new areas of investigation, while sustaining the level of our current efforts and supporting talented scientists using novel methodologies to explore new ideas and concepts that were impossible to envision only a few years ago.

Today's Scientific Advances Are Tomorrow's Medicine

Consider how more predictive and personalized treatments could improve the safety and effectiveness of medications. The same medication can help one patient and be ineffective for, or toxic to, another. With the emergence of a field of research called pharmacogenomics, we will increasingly know which patients will likely benefit from treatment and which will not benefit, or worse, be harmed. Cancer chemotherapy and the use of the anticoagulant Coumadin are good examples of how this might be applied.

Research on viruses is improving the lives of Americans and people around the world. NIH supported the early research that led to the discovery and development of antiretroviral therapies for HIV/AIDS. Today, antiretroviral therapies are benefitting millions of Americans as the most effective means of treating HIV infections. These therapies are also helping millions of people in Africa and the Caribbean through the President's Emergency Plan for AIDS Relief.

Current HIV/AIDS therapies focus on the virus itself. Researchers are trying to understand how the virus enters the human cell and hijacks the cellular machinery, so it can replicate and spread. In a recent experiment, researchers made significant progress toward reaching this goal. Their new approach is based on a process called RNA interference discovered in 1998 and recognized with a Nobel Prize in 2006. Using RNA interference, the researchers suppressed the activity of every single gene in a type of human cell. They discovered more than 276 human proteins that seem essential to the replication of the HIV virus in human cells. This experiment, unthinkable a few years ago, can now be exploited to develop new ways of disabling this deadly virus.

Fundamental research can unexpectedly lead to revolutionary breakthroughs. Scientists at the National Cancer Institute, for example, developed a virus-like particle technology that formed the basis for new commercial vaccines that target specific cancers. In June 2006,

the U.S. Food and Drug Administration approved the vaccine Gardasil, which is highly effective in preventing infections from the four types of human papilloma virus (HPV) that cause the majority of cervical cancers in women. Worldwide use of this vaccine could save the lives of 200,000 women each year. This is the first example of a truly *preemptive* strategy in cancer.

More often than not, it is the sustained combination of multiple approaches—from the most basic science to epidemiological and behavioral research—that makes advances in science effective. One important public health success story is the reduction in tobacco use and related diseases. In the last decade, overall cancer death rates dropped for the first time in a century, driven largely by the dramatic reduction in male smoking from 47% in the 1960s to less than 23% today. This reduction, along with more effective early screening tools like mammography and colonoscopy, is changing the landscape of cancer mortality. These successes reflect the outcome of significant research investments made by many NIH Institutes and Centers (ICs) and our sister agencies over the last 50 years.

Our ability to predict and preempt disease also hinges on the development of new diagnostics based on recent discoveries in genomics, proteomics, systems biology, and imaging. Among the diagnostic capabilities currently being explored are:

- Point of Care Diagnostic Testing – NIH supports research that has and will develop technologies that offer instant diagnosis in the emergency room or physician's office, or at home, including rapid analysis of blood for assays such as chemistry, electrolytes and blood gases; biosensors that instantly detect signs of heart disease or infections; and biochips that detect disease processes at the molecular level.
- Salivary Diagnostics – Scientists identified genes and proteins expressed in salivary glands that we believe will replace some forms of urine or blood analysis in the detection of cancer, heart disease, diabetes, and other conditions.
- Optical Imaging – NIH-supported researchers are developing imaging techniques that seek to reduce the need for invasive diagnostic procedures. These new tools include fiber optic probes to detect malignant tissues, with the potential of avoiding invasive biopsies with a more accurate method of analysis; optical coherence tomography to identify heart disease; and multiphoton microscopy to study living cells and tissues.
- Brain-Wiring Diagrams – NIH-supported researchers developed a way to reveal connections made by a single nerve cell in living tissue. We hope one day to construct a wiring diagram of the billions of nerve cells that constitute the brain's visual centers that might allow us to diagnose and treat vision loss with far more success – an advance that has implications for many other brain diseases as well.
- Autism Genes – Research into autism discovered clues that rare genetic changes represent a risk for autism. With this preliminary result, we are on at least one path to understanding methods of predicting autism risk in infants.

The Challenges that Lie Ahead

We are optimistic about by recent discoveries. However, there are challenges that lay ahead of us. The budget request provides \$29.5 billion to help fill gaps in our fundamental understanding of health and disease. We still need to focus much of our efforts on fundamental research. New threats and diseases constantly emerge. For example, soldiers suffering from blast injury highlight the importance of additional knowledge on traumatic

brain injuries. Infectious diseases remain among the leading causes of death worldwide. More than 30 newly recognized infectious diseases and syndromes emerged in the last three decades alone, including HIV/AIDS and SARS. Infectious diseases that once seemed to be fading, such as tuberculosis and malaria, have resurged. New drug-resistant forms of once-easily treated microbial infections are emerging at a rapid pace. New strains of influenza occur each year. There is concern that a new influenza virus may emerge with the capacity for sustained human-to-human transmission, possibly triggering a pandemic similar to what occurred in 1918, 1957, and 1968.

The tragic events of September 11, 2001, and the deliberate release of anthrax in the Nation's capital, drove home the realization that certain deadly pathogens, such as smallpox or anthrax, could be used deliberately as agents of bioterrorism against the civilian population – similar to radiological, nuclear, and chemical threats. Research in these arenas is critical to meeting these threats, and \$1.7 billion is included in FY 2009 budget for such NIH-supported research.

Efforts to prevent, detect, and treat disease require better understanding of the dynamic complexity of the many biological systems of the human body and their interactions with our environment at several scales—from atoms, molecules, cells and organs, to body and mind. As the questions become more complex, and even as knowledge grows, research itself becomes more multi-faceted. We recognize that to effectively push science/new knowledge forward, researchers and scientists must begin to work more collaboratively to develop unifying principles that link apparently disparate diseases through common biological pathways and therapeutic approaches. Today, and in the future, NIH research must reflect this new reality. Advanced technologies, including sophisticated computational tools and burgeoning databases, need to be more widely shared with easy and public access. The scale and intricacy of today's biomedical research problems increasingly demand that scientists move beyond the borders of their own disciplines and apply new organizational and interdisciplinary models for science. One of NIH's most pressing challenges is to generate and maintain the trained and creative biomedical workforce necessary to tackle the converging and daunting research questions of this century.

Many of our public health problems have a behavioral component. To put evidence-based interventions into place, all of society must participate. To confront obesity, NIH researchers must continue to address a multitude of intersecting factors, from inherent biological traits that differ among individuals, to environmental and socioeconomic factors and behavioral factors that may have molecular and environmental influences. NIH developed innovative intervention programs such as the WE CAN (Ways to Enhance Children's Activity & Nutrition), now in several hundred communities. WE CAN is designed to help children maintain a healthy weight by promoting improved food choices, increased physical activity, and reduced screen time.

NIH's primary mission is to develop new knowledge in biology and behavior and to apply this knowledge for the benefit of all. NIH is taking a more proactive role in helping to translate these discoveries into practice. For example, we have engaged in the most profound reform of translational and clinical research in the United States in over 50 years. The NIH Common Fund (CF), a new clinical and translational science program, now

supports 33 academic centers of excellence charged with the dual task of translating research from the laboratory to patients and discovering the most effective ways of implementing what we know best at the community level. Success in these endeavors depends heavily on our ability to train a new generation of clinician-scientists steeped in modern methodologies and concepts of basic and translational research. This new generation of researchers must be able to work seamlessly with basic and applied scientists in an interdisciplinary environment.

Through our ICs, NIH conducts many comparative effectiveness trials that provide evidence for more effective strategies of care. In collaboration with the Centers for Medicare and Medicaid Services (CMS), NIH is now launching a comparative effectiveness study of two drugs (Avastin and Lucentis) with different costs that are used to block growth of abnormal blood vessels in patients with age-related macular degeneration (AMD). If the less-expensive drug proves effective, it could drastically reduce the costs to CMS for treating AMD. Many similar NIH-supported comparative effectiveness trials are uncovering evidence that shows, for example, that older generic drugs can often be as effective as newer medications in the treatment of high blood pressure (ALLHAT trial), or certain mental health disorders (CATIE trial). In order to disseminate these results, ALLHAT investigator-educators made 1,696 presentations to 18,905 clinicians in 42 states and Washington, DC.

Given the structure of our healthcare system, it is often difficult for providers to implement the evidence from these large NIH trials. This challenge is real and requires that all relevant parties work collaboratively toward a more systemic approach that goes beyond simply conducting more research of this type. All healthcare components must come together to develop clear follow-through mechanisms to implement the evidence generated by these large trials.

Our Nation Must Spur Innovation

With the NIH Reform Act of 2006 (P.L. 109-482), Congress provided a foundation for the centerpiece of the NIH Common Fund (CF) for Medical Research that provides “incubator space” to spur innovation. The CF supplies a centralized source of funding for trans-NIH initiatives to meet the research and training needs of the 21st century and stimulate innovation. Research initiatives supported by the CF must not only be trans-NIH and fill a gap in our knowledge base but also be potentially transformative. The CF invests in systems biology, interdisciplinary research, biocomputing and clinical research, all of which are fundamental to moving biomedical research forward expeditiously. The budget request includes \$534 million for such activities.

The Human Microbiome project is one such initiative. It promises to reveal how bacteria and other microorganisms that are found naturally in the human body (the “microbiome”) influence a range of biological processes, including development, immunity, and nutrition. This effort will not only improve our understanding of how an individual’s microbiome relates to disease, but will also support the development of new technologies and computational approaches—all cross-cutting outputs that can be applied to investigations of other biosystems.

Another new initiative at the biomedical research frontier is the NIH Epigenomics Program. It will scan the human genome to study heritable features that do not involve changes to the underlying DNA sequence, but significantly affect gene expression and inform us about how DNA is regulated. This analysis of epigenetic changes should reveal new cellular pathways and mechanisms that influence disease progression. Also, the CF continues to support other important initiatives, such as the Pioneer Award program for \$36 million in FY 2009 which nurtures high risk ideas that, if successful, can have unusually high scientific impact.

Nurturing a new generation of innovators is critical to our future research endeavors. NIH makes strategic investments at every point in the pipeline to improve the flow of talent drawn from every part and population of America. We produce teaching supplements to help educators in grades 2 through 12 convey difficult concepts through engaging activities, improving health literacy, and hopefully sparking children's interests in careers in research. NIH offers undergraduate students research experiences, especially geared toward tapping the vast potential of young people from historically underrepresented groups in the sciences. NIH grants fund graduate students and post-doctoral fellows, who go on to fill most every niche in the American biomedical research enterprise—from academic research to private industry, and from venture capitalists to policy makers. But most importantly, young people need to see, at all stages of the pipeline, that biomedical research is an attractive career. They need to see that there is a stable research enterprise, providing them opportunities to explore their best ideas for improving human health. The budget request includes \$123 million for individual fellowship awards under the Ruth L. Kirschstein program.

NIH-supported scientists continue to discover the fundamental underpinnings of human biology in all of its complexity through investigator-initiated research, the mainstay of creativity in science. Thus, one of the top budget priorities is to sustain the number of competing Research Project Grants (RPGs). The budget funds essentially the same level of competing RPGs in 2009 as estimated in 2008—about 9,760 RPGs at \$3.5 billion. Overall, NIH will support nearly 38,260 RPGs at \$15.5 billion. This was accomplished, in part, by holding down inflationary increases for existing and new grants.

One example of our efforts to sustain the research enterprise is the Director's Bridge Awards, which funded 244 meritorious scientists in 2007 who would have otherwise lost funding. It preserves the U.S. investment in investigators, laboratories, and the research projects deemed essential to our mission. We expect to continue this successful approach in 2009.

Our priorities continue to focus on maintaining a competitive and viable scientific support system, especially for new and early-career scientists. Our long-term demographic projections show the aging of the Nation's scientific workforce. Unless we take an immediate and substantial proactive stance in protecting early-career scientists, this situation will have a negative and long-lasting impact on our competitiveness and innovation as a Nation. In 2007, we set a goal for the number of new career investigators based on the historic five year average of more than 1,500 – it was surpassed. This represented a substantial increase in new career investigators over the number in 2006 of 1,353. We plan to continue this commitment in 2008 and 2009.

In 2007 and 2008 we also targeted earlier career stages, such as the Pathway to Independence Awards, supported by all NIH ICs. These awards provide 5 years of support for over 170 postdoctoral trainees a year to encourage risk-taking and independence. NIH plans to fund over 350 postdoctoral scientists by the end of 2008 and continue the program in 2009. The budget request includes \$56 million for the New Innovator Awards, which support newly-independent scientists with novel ideas and potentially large scientific impact. Scientists must be within the first 10 years of receiving their doctoral degree to qualify. NIH funded 30 awards in 2007 and plans to maintain this promising program.

Summary

At NIH, building toward the future involves innovations in multiple areas. We are in the midst of an explosion of new discoveries and novel opportunities for progress across all areas of science—from the most basic discoveries, such as the sequencing of the human genome, to the development of fields—like nanotechnology—that did not exist a few years ago. These advances have dramatically expanded the scope and capacity of the Nation's research enterprise, a goal and outcome of the doubling of the NIH budget.

This remarkable growth in research capacity was accomplished, in part, by leveraging NIH and private sector resources to nurture more investigators, develop new technologies, and build infrastructure. The Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs, helps entrepreneurs, as they translate science to market products to improve health and help maintain American economic leadership. A total of 4,350 new technologies were brought to market by 189 universities, hospitals, and private research institutions from 1998 through 2006. From 1980 to 2006, a total of 5,724 new companies were formed around technologies developed by research institutions, many directly funded by NIH. The U.S. is now the preeminent force in biomedical research. Our Nation continues to lead the highly competitive biotechnology and pharmaceutical sectors. Yet, we are also the focus of increasing competition from growing research in Europe and Asia. NIH programs produce steady streams of novel discoveries and innovative researchers that flow into our industries, making them more competitive. We must continually sustain the momentum of U.S. biomedical research, or risk losing it. Complacency is unacceptable!

We stand today at a crossroads in our efforts to improve health. Healthcare costs are rising. As a society, we must commit to moving forward and capitalize on the momentum created by advances in science and technology. We need to sustain this momentum. Progress in the life sciences in this century will be a major determinant of our Nation's health, its competitiveness, and its standing in the world. This is truly a race against time—a race that we cannot afford to lose.

Dr. Elias A. Zerhouni

NIH Director, Elias A. Zerhouni, M.D., leads the nation's medical research agency and oversees the NIH's 27 Institutes and Centers with more than 18,000 employees and a fiscal year 2008 budget of \$29.5 billion.

The NIH investigates the causes, treatments, and preventive strategies for both common and rare diseases, helping to lead the way toward important medical discoveries that improve people's health and save lives. More than 83% of the NIH's funding is awarded through almost 50,000 competitive grants and awards to more than 300,000 scientists and research support staff at more than 3,000 universities, medical schools, and other research institutions in every state and around the world. About 10% of the NIH's budget supports projects conducted by nearly 6,000 scientists in its own laboratories, most of which are on the NIH campus in Bethesda, Maryland.

Dr. Zerhouni, a world renowned leader in the field of radiology and medicine, has spent his career providing clinical, scientific, and administrative leadership. He is credited with developing imaging methods used for diagnosing cancer and cardiovascular disease. As one of the world's premier experts in magnetic resonance imaging (MRI), he has extended the role of MRI from taking snapshots of gross anatomy to visualizing how the body works at the molecular level. He pioneered magnetic tagging, a non-invasive method of using MRI to track the motions of a heart in three dimensions. He is also renowned for refining an imaging technique called computed tomographic (CT) densitometry that helps discriminate between non-cancerous and cancerous nodules in the lung.

Since being named by President George W. Bush to serve as the 15th Director of the National Institutes of Health in May 2002, Dr. Zerhouni has overseen a number of milestones:

Reauthorization demonstrated renewed confidence in NIH

Congress passed and President Bush signed into law the National Institutes of Health Reform Act of 2006. The agency's third reauthorization in history and first since 1993, it signaled renewed confidence in the NIH mission, its employees and its leadership. The new law provides the NIH director expanded authority to manage the agency, encourages NIH Institutes and Centers (ICs) to collaborate on trans-NIH research and reforms the agency's reporting system. Reauthorization will strengthen the links within NIH and between the intramural and extramural research communities. Ultimately, it will help NIH more effectively balance what has traditionally worked in science — freedom of exploration, autonomy, decentralization — with providing opportunities for people to collaborate and cooperate more freely.

Development of a new office to improve trans-NIH initiatives

In 2005, NIH launched the Office of Portfolio Analysis and Strategic Initiatives (OPASI) in the Office of the NIH Director to transform the way NIH finds and funds cutting-edge research, improve our ability to identify public health challenges, and increase trans-NIH dialogue, decision-making and priority-setting. OPASI will build

upon the model of the NIH Roadmap for Medical Research and will coordinate with NIH ICs and external stakeholders to identify research priorities that will ultimately improve NIH's ability to be nimble, dynamic, and responsive to emerging scientific opportunities and public health needs.

Although OPASI will not have grant-making authority, it will provide an "incubator space" to jump-start trans-NIH initiatives and support ICs that will take the lead on priority projects on a time-limited basis (5 to 10 years). These OPASI initiatives will be supported by the "Common Fund for Shared Needs," a central funding source built upon the Roadmap budget model. Building from current Roadmap funds, which amount to about 1.6 percent of NIH's total budget in fiscal year 2007, the Fund will increase to up to 5 percent of the total NIH budget depending on NIH budget growth, scientific opportunities and public health needs.

Initiated the NIH Roadmap for Medical Research

Launched in September 2003, the NIH Roadmap for Medical Research, a new research vision to accelerate medical discovery to improve health, focuses the attention of the biomedical research community on new pathways of discovery, research teams for the future and the re-engineering of the clinical research enterprise. It aims to accelerate the pace of discovery and speed the application of new knowledge to the development of new prevention strategies, new diagnostics and new treatments, and, ultimately, to the transfer these innovations to health care providers, and the public.

Established an NIH-wide research initiative to address the obesity epidemic

The Strategic Plan for NIH Obesity Research is a multi-dimensional research agenda that addresses one of the nation's most dramatic health challenges. In the U.S. population, recent figures show that 65 percent of adults—or 130 million people are overweight or obese. The strategic plan enhances both the development of new research in areas of greatest scientific opportunity and the coordination of obesity research across the NIH. The plan calls for interdisciplinary research teams to bridge the study of behavioral and environmental causes of obesity with the study of genetic and biologic causes.

Supported the NIH Neuroscience Blueprint

Mental illness, neurological disorders and a range of behavioral disorders are major causes of human suffering and contribute greatly to the burden of disease. These illnesses exact a cost of \$500 billion each year. NIH Directors from 17 Institutes and Centers have developed a model of strategic leadership to address several of the most common causes of death and disability, as well as rare disorders that affect the brain, spinal cord, or nerve cells throughout the body. The blueprint leverages the abilities of the Institutes and Centers to create new resources, tackle common scientific problems, and train the next generation of neuroscientists through collaboration and leadership.

Supported the reduction of health disparities and barriers to opportunity for minority individuals

"Broadening the collaborative relationships developed through partnerships between NIH and institutions and researchers from all populations," is the focus of

Dr. Zerhouni's commitment to eliminating health disparities and disparities in the burden of disease. In 2007, NIH announced the awarding of \$66.7 million to support the advancement of health disparities research. This was the most recent in a series of commitments of funds to this research. NIH has made 58 awards under the Centers of Excellence program. NIH as a whole expects to spend \$2.7 billion on research funding for health disparities.

Ensured public access to NIH-funded research results

February 3, 2005, Dr. Zerhouni announced an historic public access policy. For the first time, the public will have access to peer-reviewed research publications that resulted from studies funded by NIH. Dr. Zerhouni has urged maximum participation by investigators, encouraging scientists to submit their publications as soon as possible and within twelve months of publication to the archive.

Committed to earn the public's trust

Dr. Zerhouni continues to seek advice from the public through the Council of Public Representatives (COPR), a recent public trust workshop, and, more locally, through community liaison efforts. He is committed as well to producing the most scientifically-accurate, useful and accessible health information through public health campaigns, fact sheets, over the Web and through a full complement of outreach efforts with special attention to cultural competence designed to keep the public informed.

Enhanced the leadership of NIH

Since becoming the NIH Director, Dr. Zerhouni named a new NIH Deputy Director (Raynard S. Kington, M.D., Ph.D.) and directors for nine institutes and four centers: Center for Scientific Review (Antonio Scarpa, M.D., Ph.D.), John E. Fogarty International Center (Roger I. Glass, M.D., Ph.D.), National Cancer Institute (John E. Niederhuber, M.D.), National Center for Research Resources (Barbara Alving, M.D.), National Heart, Lung, and Blood Institute (Elizabeth G. Nabel, M.D.), National Institute of Diabetes and Digestive and Kidney Diseases (Griffin P. Rodgers, M.D.), National Institute of Environmental Health Sciences and the National Toxicology Program (David A. Schwartz, M.D.), National Institute of General Medical Sciences (Jeremy M. Berg, Ph.D.), National Institute of Mental Health (Thomas R. Insel, M.D.), National Institute of Neurological Disorders and Stroke (Story C. Landis, Ph.D.), National Institute on Alcohol Abuse and Alcoholism (Ting-Kai Li, M.D.), National Institute on Drug Abuse (Nora D. Volkow, M.D.), and National Center for Complementary and Alternative Medicine (Josephine Briggs, M.D.).

Prior to joining the NIH, Dr. Zerhouni served as executive vice-dean of Johns Hopkins University School of Medicine, chair of the Russell H. Morgan department of radiology and radiological science, and Martin Donner professor of radiology, and professor of biomedical engineering. Before that, he was vice dean for research at Johns Hopkins.

Dr. Zerhouni was born in Nedroma, Algeria and came to the United States at age 24, having earned his medical degree at the University of Algiers School of Medicine in 1975. After completing his residency in diagnostic radiology at the Johns Hopkins University School of Medicine as chief resident (1978), he remained at Hopkins, serving as instructor

(1978–1979) and then as assistant professor (1979–1981). Between 1981 and 1985 he was in the department of radiology at Eastern Virginia Medical School and its affiliated DePaul Hospital. He returned to Johns Hopkins as an associate professor in 1985. In 1988, Dr. Zerhouni was appointed director of the MRI division. He was promoted to full professor of radiology in 1992 and of biomedical engineering in 1995. In 1996, he was named chairman of the radiology department.

Since 2000, he has been a member of the Institute of Medicine. He served on the National Cancer Institute's Board of Scientific Advisors from 1998–2002. He was a consultant to both the World Health Organization (1988), and to the White House under President Ronald Reagan (1985).

A resident of Baltimore, he has won several awards for his research including a Gold Medal from the American Roentgen Ray Society for CT research and two Paul Lauterbur Awards for MRI research. Earlier this year, Dr. Zerhouni received the Special Presidential Award of the European Congress of Radiology. His research in imaging led to advances in Computerized Axial Tomography (CAT scanning) and Magnetic Resonance Imaging (MRI). He is the author of 212 publications and holds 8 patents.

Department of Health and Human Services
Office of Budget
Richard J. Turman

Mr. Turman is the Deputy Assistant Secretary for Budget, HHS. He joined federal service as a Presidential Management Intern in 1987 at the Office of Management and Budget, where he worked as a Budget Examiner and later as a Branch Chief. He has worked as a Legislative Assistant in the Senate, as the Director of Federal Relations for an association of research universities, and as the Associate Director for Budget of the National Institutes of Health. He received a Bachelor's Degree from the University of California, Santa Cruz, and a Masters in Public Policy from the University of California, Berkeley.

Mr. OBEY. Dr. Gerberding.

OPENING STATEMENT

Dr. GERBERDING. Thank you very much. It is a real honor to be here and to have a chance to appear with my colleagues. I am sure I am going to learn a lot more from this hearing than I will contribute, and I am very grateful for that.

I would like to pick up where Dr. Zerhouni left off and talk a little bit about how health happens.

There are three questions that plague us at CDC. One is why, if we are the Nation that spends the most on health, aren't we the healthiest Nation? We are actually 37th in the world according to the WHO. Why might our children have shorter lifespans than their parents and, fundamentally, why is obesity becoming a national security concern in the United States?

I think those are all three reflections of the fact that we just simply do not have the value in our health system that we need, and part of that has to do with, again, fundamentally rethinking about how health happens.

So if I can have my slides, I want to just start with the traditional healthcare delivery system, starting with the discovery phase at the NIH and CDC and elsewhere, moving to patients through translation, bench to bedside, then translation into evidence-based practice guidelines, something my colleague Dr. Clancy knows a lot about, and from there really being translated into widespread clinical practice so that everybody can benefit and, finally, we hope, the fourth level of translation into achieving the kinds of true health outcomes and benefits to all people.

The problem in our Country right now is that this last element is particularly blocked. People are worried about access and cost in care. It doesn't matter if you read the New England Journal or whether you are Republican or Democrat, this is a major concern for people everywhere, and we know that we have major problems in these areas.

But even if we alleviated these problems, we would still not necessarily have the health that we want because the health in our Country has more to do with things that happen outside of the doctor's office than it does with things that happen inside of the doctor's office. That is where the public health system comes in, and that is why the investments that we make there are so very, very important.

So we think that there is a comparable highway to health that is not one that is receiving the attention that it deserves, but one that is equally, if not more, important in getting us to a healthy Nation.

It starts again with research. That gets translated to people in communities and schools and the workplace. From there, we develop public health practice guidelines, evidence-based practices, the things we know work. Then we need to translate those into widespread uptake so that health departments in communities everywhere can benefit from them. Finally, then, we see that health, as we measure it in a holistic way in our society, ultimately will be achieved.

Both of these highways have to be functional, and investments in both of these areas contribute to people's health and, I think, ultimately to our ability to be one of the healthiest nations in the world, a status that we do not currently enjoy.

There are lots of things that we know work and lots of things we can talk about scaling up, ways we can put health and policies beyond the policies in this Committee, health in agriculture, health in transportation policies, health in commerce policies.

I think there is also a very important need to market what we know works and to get it diffused and disseminated and taken up widely, using some of the new technologies that we have at our disposal today so that people everywhere can benefit.

[The information follows:]



TESTIMONY BEFORE THE

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION AND RELATED AGENCIES

UNITED STATES HOUSE OF REPRESENTATIVES

Health Issues and Opportunities at CDC

Statement of

Julie L. Gerberding, M.D., M.P.H.

*Director, Centers for Disease Control and Prevention,
U.S. Department of Health and Human Services*

Accompanied by

Bill Nichols, MPA, Director, Financial Management Office, CDC

Richard Turman, Deputy Assistant Secretary, Budget



For Release on Delivery
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Good afternoon, Mr. Chairman, Congressman Walsh, and other distinguished Members of the Subcommittee. It is a pleasure to appear before you again as Director of the Centers for Disease Control and Prevention (CDC), the nation's leading health protection agency and an operating division of the Department of Health and Human Services. Today I would like to focus on the essential contribution the public health system, with CDC's leadership, is positioned to make in moving our country toward improved health. We need more than improved performance in our health care delivery system and better access to care – we need to develop a comprehensive health system that not only delivers care and services, but also protects and promotes good health in all communities. If we do this successfully, America can become one of the world's healthiest nations.

CDC's primary focus is on protecting health, rather than treating illness; in doing that through health promotion, prevention and preparedness, rather than disease care; and on creating holistic approaches for improving people's health across all stages of life. We center our efforts on a set of fundamental Health Protection Goals designed to accelerate health improvement, reduce health disparities, and protect people at home and abroad from current and new health threats. These goals drive our research priorities and our programs and interventions.

Let me begin by describing the role of CDC and our public health partners in protecting health in this country. I will then describe opportunities and investments in health protection, including some of the key priority areas in the President's fiscal year (FY) 2009 budget request for CDC. I will close by highlighting just a few examples of CDC achievements that illustrate how we contribute to a healthier nation.

The Role of Public Health in the Nation's Health System

Many of the greatest opportunities today for improving people's health fall outside the traditional health care system. The public health system aims to enhance quality of life across the lifespan, to prevent costly diseases before they reach the health care system, and to improve economic competitiveness by a safer and healthier workforce. We see lost opportunity at a population level when infant mortality and life expectancy in the United States fall behind that of other developed countries, and when we place our children at risk of having a life expectancy lower than our own. We see lost opportunity at an individual level when practical prevention steps are not taken, and the path toward treatment for disease is the only viable option. We need a focus on protection of health and prevention of disease, injury and disability before the onset of these conditions. When we invest in health protection, we can turn these lost opportunities into public health achievements – to realize our long term goal of becoming the healthiest nation.

We must do more than improve our ability to safely and cost-effectively treat diseases; we must create a true health system that measures, values, and rewards health promotion and disease prevention as much or even more than disease care. If we invest in a strong public health system, with programs designed to protect people where they live,

work, study and play, and foster linkages to a robust health care system, we can achieve the common objective of better health for all. In this transformed system, we would reach a balance between protecting health and providing the best possible disease care. Building on the knowledge generated by biomedical research and our world class treatment system, we can bring the scientific expertise of CDC and others to bear on protecting health before serious complications develop. With CDC at the helm, the public health network in our states and communities is positioned to play a lead role in health system transformation.

Opportunities and Investments in Health Protection

CDC continues to identify and implement effective strategies to protect health and prevent disease, injury and disability for anyone, anytime, any place. These strategies are diverse and wide-ranging and involve every part of the agency working collaboratively to achieve better health. From a life stage perspective, we are working to improve health through research into the causes of birth defects, child maltreatment and youth violence prevention, and immunization efforts for both children and adults. We are promoting healthy places through support for walkable communities, occupational safety measures, health promotion in schools and worksites, and prevention of infections in health care settings. We continue to advance preparedness for emerging health threats by enhancing risk communications methodologies, developing informatics systems to integrate and analyze disparate information in real time, and building capacity for community-based surveillance and control of infectious disease. We are expanding the public's access to credible health information through health marketing, new media, and innovative e-health interventions. And we are working to improve global health through such efforts as promoting safe water and distributing insecticide-treated bed nets to prevent malaria. These are just a few examples of the innovative work CDC is doing in collaboration with many partners to protect health.

The FY 2009 budget request for CDC contains a number of investments that will further advance the capacity of the public health system to combat health threats at home and abroad. An increase of nearly \$20.0 million is requested for the Strategic National Stockpile, enabling CDC to continue to purchase, warehouse and manage medical countermeasures to respond to a catastrophic health event, whether naturally occurring or manmade. An additional \$10.3 million is requested to upgrade capacity within the Laboratory Response Network for detecting and responding to radiological events. An increase of \$33.4 million to expand the U.S. Quarantine and Migration Health System will leverage CDC's ability to protect the public from disease threats before they arrive at our borders, and targeted efforts to prepare for an influenza pandemic will continue in FY 2009 with an additional request of \$3.1 million. The threat of an influenza pandemic has not diminished and CDC remains committed to preparing for the full spectrum of public health threats.

In addition, the FY 2009 budget request includes an overall investment of \$93.0 million for the President's Domestic HIV/AIDS Testing Initiative to support additional testing activities and early diagnosis in medical and community-based settings. And, as we look for opportunities to improve our nation's health, we recognize the importance of

obtaining reliable, high quality data to guide and evaluate decisions about changes that may be pursued in our health care system. Increased investment of \$11.1 million for health statistics will sustain and enhance a variety of surveys and statistical programs which provide comprehensive data essential to public health decision-making at CDC, within HHS, and across all levels of government. To advance our monitoring and surveillance capacity, an increase of \$15.5 million is requested for the BioSense surveillance system to enable real-time situational awareness during public health emergencies and to make that information useful at the local, state, federal and international levels. These investments will help CDC continue to provide accurate, timely health estimates and high priority interventions needed by public health, health care, homeland security and many other sectors.

Impact and Accomplishments

CDC is focused on achieving ever-greater impact on the health of the people and places we serve, domestically and internationally. We are committed to effectiveness and efficiency in our programs to ensure the greatest impact, and we are working strategically to solve complex emerging threats to health. Let me close by highlighting just a few examples of what CDC has achieved over the past year in each of our key health protection goal areas.

Healthy People in Every Stage of Life

Addressing Disparities in Diabetes Risk Factors at a Community Level

CDC's Racial and Ethnic Approaches to Community Health (REACH) program supports community adoption of evidence-based interventions that reflect distinct cultures and local realities. To address increasing burden of diabetes among the Hispanic population, the REACH program in Hidalgo County (NM) is working in partnership with local community groups to implement the La Vida (Lifestyles and Values Impact Diabetes Awareness) Program. La Vida offers diabetes education classes, support groups, community outreach, and grocery store tours that include instructions on how to read food labels. Median A1c levels, which measure blood glucose control to help determine risk for diabetes complications, dropped significantly among Hidalgo Medical Services patients within one year of involvement in the program. This is one example of a successful community-based intervention that is helping to improve health across life stages.

Healthy People in Healthy Places

Preventing Fire-related Injuries among Older Adults

To reduce fire-related injuries and loss of life and property among homebound older adults, CDC is partnering with the Meals on Wheels Association of America to implement the Residential Fire Homebound Elderly Lifeline Project (*Fire H.E.L.P.*). This initiative involves home screening for smoke alarms; education on fire risk factors and escape planning; and installation and periodic testing of free smoke alarms with long-life batteries. During this partnership's pilot phase in five Texas communities, local fire departments have assisted in installing approximately 5,000 smoke alarms in the homes of older adults, reducing the risk of fire-related injury and saving lives.

People Prepared for Emerging Health Threats

Combating Foodborne Illness

CDC's systems for monitoring and containing outbreaks of foodborne illness are increasingly important in light of recent high profile outbreaks and public concern over the safety of the food supply. For example, in early 2007, CDC's coordination of surveillance, epidemiology, and laboratory systems helped to link 715 cases of Salmonella infection in 48 states to peanut butter produced at a single factory. This led to a large product recall, the closing and rebuilding of the factory, and increased attention by our regulatory partners to dry processed foods. Through collaborative research efforts, we can develop a better understanding of the sources and ecologies of foodborne disease in order to establish more effective control and prevention measures.

Healthy People in a Healthy World

Hunting Down the Source of the Deadly Marburg Virus

CDC's international presence allows us to mobilize quickly and efficiently for global outbreak response. For example, when two miners fell ill with Marburg hemorrhagic fever at the Kitaka mine in Uganda in early August 2007, CDC staff worked with the Ugandan Ministry of Health to quickly identify the etiology, contain the outbreak, and act on a rare opportunity to trace the outbreak to its source. CDC also assisted in tracing every known contact of the infected miners through the 21-day incubation period to ensure that the outbreak had been contained. By the time the CDC team left Uganda in early September, they and partners from South Africa had collected more than 1,000 bats from the Kitaka mine. Ongoing testing may further elucidate the role of bats in the maintenance of Marburg virus in nature, uncover the mode of transmission to humans, and guide development of measures to prevent infection. The results of these studies will aid CDC's goal of protecting people in the U.S. and abroad from emerging health threats.

Moving Forward

Thank you for the invitation to appear before the Subcommittee this afternoon to highlight CDC's role in protecting public health. I look forward to a sustained dialogue as we work towards health system transformation over the long term, with public health and health care acting as equal partners in this important effort. If we are to begin to engage in a broad effort to improve the health of the population, we must continue to leverage our resources and broaden our emphasis as a nation to include health protection as well as disease care. Making health a priority in the U.S. will require renewed synergy between the population-based health protection efforts of CDC and its partners, and the clinical prevention and individualized disease care efforts of the health care delivery system. Thank you for your continued support of our important work, and I would be happy to answer any questions.

Biographical Sketch – Dr. Julie Louise Gerberding, M.D., M.P.H.

Julie Louise Gerberding, M.D., M.P.H., became the Director of the Centers for Disease Control and Prevention (CDC) and the Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR) on July 3, 2002.

Before becoming CDC Director and ATSDR Administrator, Dr. Gerberding was Acting Deputy Director of the National Center for Infectious Diseases (NCID), where she played a major role in leading CDC's response to the anthrax bioterrorism events of 2001. She joined CDC in 1998 as Director of the Division of Healthcare Quality Promotion, NCID, where she developed CDC's patient safety initiatives and other programs to prevent infections, antimicrobial resistance, and medical errors in healthcare settings. Prior to coming to CDC, Dr. Gerberding was a faculty member at the University of California at San Francisco (UCSF) and directed the Prevention Epicenter, a multidisciplinary research, training, and clinical service program that focused on preventing infections in patients and their healthcare providers. Dr. Gerberding is a Clinical Professor of Medicine (Infectious Diseases) at Emory University and an Associate Professor of Medicine (Infectious Diseases) at UCSF.

She earned a B.A. magna cum laude in chemistry and biology and a M.D. at Case Western Reserve University in Cleveland, Ohio. Dr. Gerberding then completed her internship and residency in internal medicine at UCSF, where she also served as Chief Medical Resident before completing her fellowship in Clinical Pharmacology and Infectious Diseases at UCSF. She earned a M.P.H. degree at the University of California, Berkeley in 1990.

Dr. Gerberding is a member of Phi Beta Kappa, Alpha Omega Alpha (medical honor society), American Society for Clinical Investigation (ASCI), American College of Physicians, Infectious Diseases Society of America, the American Epidemiology Society, the National Academy of Public Administration, and the Institute of Medicine. In the past, Dr. Gerberding served as a member of CDC's National Center for Infectious Diseases' Board of Scientific Counselors, the CDC HIV Advisory Committee, and the Scientific Program Committee, National Conference on Human Retroviruses. She has also been a consultant to the National Institutes of Health, the American Medical Association, CDC, the Occupational Safety and Health Administration, the National AIDS Commission, the Congressional Office of Technology Assessment, and the World Health Organization.

Dr. Gerberding's editorial activities have included appointment to the Editorial Board of the Annals of Internal Medicine; appointment as an Associate Editor of the American Journal of Medicine; and service as a peer-reviewer for numerous internal medicine, infectious diseases, and epidemiology journals. Her scientific interests encompass patient safety and prevention of infections and antimicrobial resistance among patients and their healthcare providers. She has authored or co-authored more than 140 peer-reviewed publications and textbook chapters and contributed to numerous guidelines and policies

relevant to HIV prevention, post-exposure prophylaxis, management of infected healthcare personnel, and healthcare-associated infection prevention.

Dr. Gerberding resides in Atlanta with her husband, David, who is a software engineer. Her step-daughter, Renada, is a law student at the University of Virginia. Dr. Gerberding relaxes by scuba diving, reading on the beach, gardening, and doting on her three cats.

Biographical Sketch – Mr. William P. Nichols, M.P.A.

William P. (Bill) Nichols became Director of CDC's Financial Management Office in October 2006, after holding the position of Director of the agency's Procurement and Grants Office from 2004 to 2006. He served previously as chief management official for the National Center for HIV, STD, and TB Prevention from 2002-2004 and for the National Immunization Program from 1995-2001, with responsibility for all human, financial, and information technology resources related to those programs.

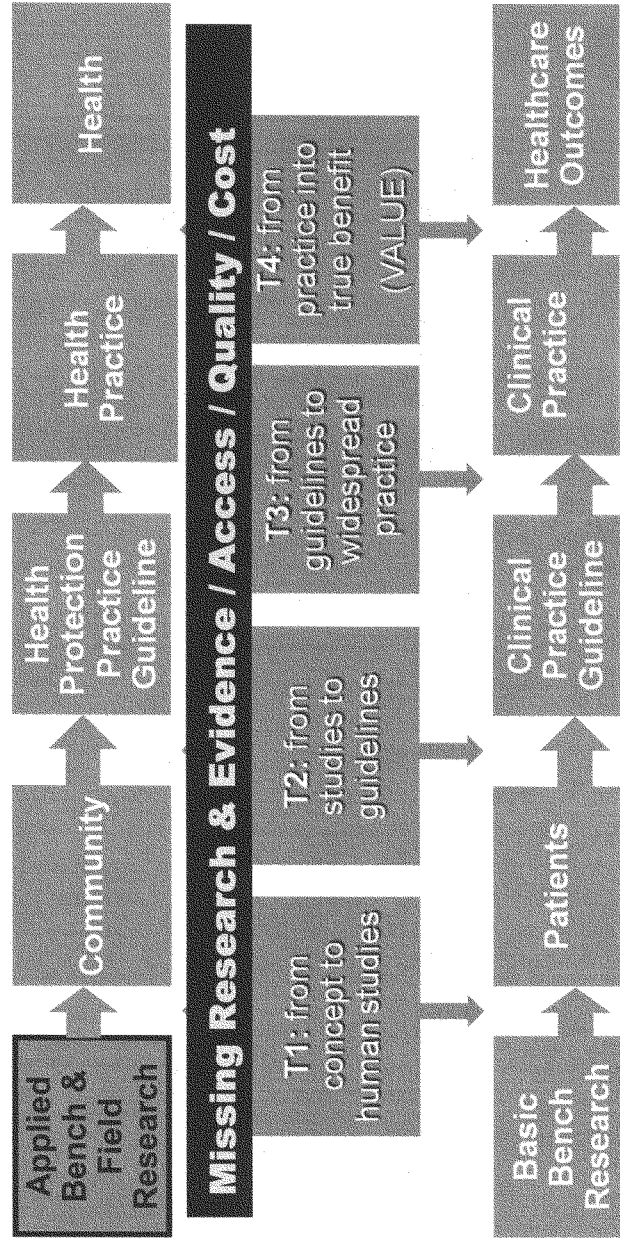
Mr. Nichols has been instrumental in the implementation of a variety of important CDC programs over his 21 year career with the agency. For example, he held a central role in implementation of the Vaccines for Children program, as well as implementation of the Advancing HIV Prevention initiative. In addition, he played a lead role in orchestrating the myriad Congressional visits to CDC following the World Trade Center catastrophe and the anthrax incidents of 2001. Mr. Nichols spent the first seven years of his CDC career assigned to State and local health departments implementing immunization and sexually transmitted disease programs. Mr. Nichols earned his Bachelor of Arts degree from Wake Forest University and a Master of Public Administration degree from Georgia State University.

Department of Health and Human Services
Office of Budget
Richard J. Turman

Mr. Turman is the Deputy Assistant Secretary for Budget, HHS. He joined federal service as a Presidential Management Intern in 1987 at the Office of Management and Budget, where he worked as a Budget Examiner and later as a Branch Chief. He has worked as a Legislative Assistant in the Senate, as the Director of Federal Relations for an association of research universities, and as the Associate Director for Budget of the National Institutes of Health. He received a Bachelor's Degree from the University of California, Santa Cruz, and a Masters in Public Policy from the University of California, Berkeley.

Translating Health Discovery to Health

Public Health System



Why isn't the United States, the country that spends the most on health, the healthiest nation?

- **Healthcare delivery issues (access, quality, cost)**
- **Public health issues**
 - Health does not happen just in the doctor's office
 - Health happens in our homes, schools, workplaces, and communities
 - We don't invest enough in protecting health – promoting good health, preventing disease, injury, and disability, and preparing for new health threats
- **We are not getting the best VALUE for what we are spending!!**

Actions for a Healthiest Nation

Health Opportunity #1 – Scale up programs that work

- Health Security
 - Healthy Babies
 - Safe Children & Adolescents
 - Fit Families
 - Protected Communities
 - Tobacco Intolerance



Actions for a Healthiest Nation

Health Opportunity #2 – Excite and Empower People

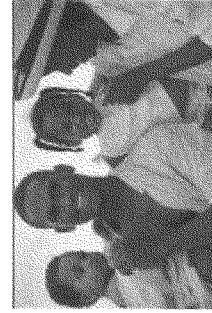
- Consumer Health Knowledge Support
 - Personalized Health and Health Records
 - Measure “Healthness”
 - eHealth Monitoring
 - Biosurveillance / Global Disease Detection
- Market “Healthness”
 - Dissemination research
 - Accelerate eHealth innovations
 - Extend “success” to all communities



Actions for a Healthiest Nation

Health Protection Opportunity #3 – Health Policy in all Sectors

- Local, state, federal, organizational health policies
 - Business/Labor: worksite safety and health promotion
 - Education: physical activity, healthy lifestyles
 - Transportation: safe walkable communities; bike lanes
 - Agriculture: access to fresh fruits and vegetables: school lunch programs; school vending machines
 - Foreign affairs: health diplomacy; protection from emerging threats
 - Health care: better value



Mr. OBEY. Dr. Cline.

Dr. CLINE. Mr. Chairman, members of the Subcommittee, thank you very much for the opportunity to be here today. I would like to request that my written testimony be submitted for the record.

During my tenure as SAMHSA Administrator, I have had the benefit of traveling across the Country and seeing the amazing results of SAMHSA-funded work. I have seen men and women reunited with their children after conquering addiction. I have seen people who are managing their mental illnesses and getting jobs and reclaiming their lives and becoming contributing members of our society.

At SAMHSA, helping more people have that opportunity to achieve these same results is a focus of work. We have also been working to move upstream to prevent many of these conditions from occurring in the first place by emphasizing the public health approach to well being, and I think this is a theme that you will see throughout the afternoon.

I learned the value of taking that public health approach as a freshly minted psychologist on the streets of Cambridge and Somerville and Boston, Massachusetts. My first professional job was providing home-based therapy to families who were living in low income housing developments in those areas.

So, as I walked to my appointments everyday, I would walk by many other families who I knew needed help as much as the family I was going to see, but I simply didn't have the time to work with the other families. I was only able to offer that therapy one family at a time.

So, walking by 15 families that I knew were in need to reach that one family just didn't seem like the right thing to do. It certainly wasn't right to do that then. It is not right to do that today. Something significant needs to change.

I remember thinking that there had to be a better way to deliver services. There had to be a better way to reach more people in need of mental health and substance abuse services in our Country.

I thought of the opportunities with those families to intervene earlier. I thought of those opportunities to actually prevent many of the problems that they were experiencing from occurring at all. That experience is why I believe so strongly that we need to adopt a public health approach in our overall work that we do.

The public health approach really involves us moving upstream while continuing the work that we are doing downstream. So while we continue to rescue those drowning individuals, we also need to move upstream and prevent to keep individuals from falling in the river in the first place.

The public health approach, as you know, recognizes that behavioral health is inextricably linked to overall health, and the integration of these is valuable and necessary. That is why I am so passionately convinced that mental illness and substance use disorders should be and must be treated with the same urgency as other health conditions.

One way to accomplish this goal of service integration is to strengthen the relationship with primary care providers. Primary care practitioners have access to a much larger segment of the population than we see in the specialty services. We need to take be-

havioral health services to the people where they are and not wait until people are in crisis.

By encouraging healthcare professionals to identify at-risk populations and to intervene early in their lives, we can significantly reduce the burden of substance abuse and mental illness among Americans and our social institutions.

There are several models of primary healthcare and behavioral healthcare integration. One particularly useful model focuses on behavioral health screening through primary care. So I would like to talk just briefly about that.

For example, through one grant program that focuses on substance abuse, SAMHSA is implementing screening, brief intervention, referral and treatment services in trauma centers, emergency rooms, community clinics, federally-qualified health centers and school clinics. These programs provide screening strategies for intervention before the individual needs those more extensive or more specialized services.

So far, our grantees have screened over 545,465 individuals across our country. Of those screened, 22.9 percent of those individuals required a brief intervention, brief treatment or referral to a specialty treatment.

At six months post-intake, 74 percent of those individuals reported lowering their drug or alcohol consumption after 1 or more brief interventions. So, of those individuals, 48 percent reported no substance use at all.

Through technology and training, we must continue to keep working to bring new knowledge, treatments, preventive strategies developed by our research institutes to daily community-based practice. We have never, ever before known so much about the prevention and treatment of mental illness and substance use disorders. Now we need to actually do what we know.

Mr. Chairman, members of the Subcommittee, I am optimistic. I look forward to the day when mental illness and substance use is treated with the same urgency as other illnesses.

I look forward to the day when a public health model ensures that preventing illness is as much a priority as treating illnesses in this Country, and I look forward to the day when we have policies and systems in place that will build resilience and facilitate recovery. Then, and only then, will we have a truly rich and healthy Nation.

I would like to thank you for the opportunity to be here today, and I look forward to answering any questions you may have. Thank you.

[The information follows:]

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Health Issues and Opportunities at the
Substance Abuse and Mental Health Services Administration
FY 2009 Budget Overview

Witnesses appearing before the
House Subcommittee on Labor-HHS-Education Appropriations

Terry L. Cline, Ph.D.
Administrator, Substance Abuse
and Mental Health Services Administration
U.S. Department of Health and Human Services

Accompanied by:

Richard Turman
Deputy Assistant Secretary, Budget

March 5, 2008

Opening

- Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to be here today. I'm pleased to share the table with colleagues from across the Department of Health and Human Services to recognize our health care successes and to suggest ways to better move what we know about health and illness to what we do to benefit the lives of the American people.
- During this past year, my first as SAMHSA Administrator, I have seen the amazing results of SAMHSA funded work in communities across the country – moms and dads reunited with their children after conquering addiction, people managing their mental illness and reclaiming their lives, getting jobs, becoming contributing members of our society, and young people working within their communities to be mentally healthy and stay drug and alcohol free.
- These life changing results flow from the clear vision SAMHSA has established for its work—a life in the community for everyone. We have sharply focused our mission on supporting States, local agencies, and individuals that are working to build resilience and facilitate recovery for people with or at risk for mental and/or substance use disorders.
- To achieve its vision and mission, SAMHSA has aligned its programs, policies and grants around 11 priority areas and cross-cutting management principles. These priorities and guiding principles are aligned and support the U.S. Department of Health and Human Services Strategic Plan and came from listening to people across the country, including Members of Congress, about what was most important for achieving our vision. Consistent with Secretary Leavitt's priority emphasis on prevention, SAMHSA is advancing the Department's agenda through a public health approach.
- I learned the value of taking a public health approach as a freshly minted clinical psychologist on the streets of Cambridge, Somerville, and Boston, Massachusetts. My first assignment was to deliver home-based therapy to families living in low-income housing developments.
- Walking to my appointments, I would think about all the people I passed by and didn't have time to help. I was only able to offer therapy one family at a time, yet practically every family in the housing development faced multi-faceted problems and needed help. Passing 15 families by to reach one seemed unacceptable – it was then and still is now.
- I remember thinking there had to be a better way to make mental health and substance abuse services available to more people. I thought of the opportunities to intervene early, or to prevent problems from occurring in the first place. The experience is also why I believe so strongly in the importance of adopting public policies that support a public health approach.
- The underlying premise of a public health approach is to promote health, reduce preventable death and disease, and to increase the span of healthy life for all Americans. A public health approach involves working "upstream," as well as "downstream." While we need to

continue to “rescue drowning individuals,” we also need to move “upstream” to try to keep people from falling in the river in the first place.

- SAMHSA’s FY 2009 Budget focuses new energy on “moving up stream,” and providing increased flexibility for States and localities to respond to their unique behavioral health needs. It includes some new initiatives, budget increases, and continues support for ongoing efforts that have demonstrated results, and targets reductions in areas where results are not demonstrated, grant periods are ending, activities can be supported through other funding streams, or efficiencies can be realized.
- Moving “upstream” drives the focus toward children and families, and harnessing the power of population-based public health functions and clinical preventive services such as screening and early intervention and linking people to needed health care services. The Budget supports moving “upstream” through an increase of \$11.4 million for the Children’s Mental Health Services Program and an increase of \$27 million for screening and early intervention.
- When it comes to mental health and substance abuse services we need to start very early in life. We know from our investments in research that half of all lifetime cases of diagnosable mental illnesses begin by age 14, and three-fourths by age 24. We also know from SAMHSA’s National Survey on Drug Use and Health that 1 in 10 adolescents 12-17 experience a significant depressive episode each year and that these young people are twice as likely to take their first drink or use drugs for the first time as those who did not experience depression.
- This SAMHSA survey also shows just how far we have to go to move “upstream” and to reduce substance abuse and mental health service needs in our country.
- In 2006, 23.6 million people aged 12 or older needed treatment for an illicit drug use or alcohol use problem. Of these, only 2.5 million received treatment at a specialty facility.
- The five most often reported reasons for not receiving treatment among those who felt they needed treatment but did not receive it were – not ready to stop using (37.2 percent), no health coverage/ could not afford cost (30.9 percent), possible negative effect on job (13.3 percent), not knowing where to go for treatment (12.6 percent), and concern that might cause neighbors/community to have negative opinion (11.0 percent).
- Also in 2006 among the 24.9 million adults aged 18 or older reporting serious psychological distress (having symptoms at a level known to be indicative of having a mental disorder) less than half 10.9 million (44.0 percent) received treatment for a mental health problem in the past year.
- Among adults who reported an unmet need for treatment or counseling for mental health problems and did not receive treatment in the past year, the top five reasons for not getting treatment were inability to afford treatment (41.5 percent), believing at the time that the problem could be handled without treatment (34.0 percent), not having the time to go to

treatment (17.1 percent), not knowing where to go for services (16.0 percent), and might cause neighbors/community to have negative opinion (10.5 percent).

- Untreated addiction and mental illnesses not only impacts the individual, it impacts almost every segment of our society including families, the workplace, communities; primary and emergency care settings; places of worship; schools; correctional facilities; and many other settings.
- For example, in the U.S., we have over 32,000 suicides every year. On average, one person dies every 16 minutes and many of these deaths are linked to substance abuse and mental illnesses.
- We have as many as 700,000 Americans who are homeless, many of whom are veterans, on any given night – an estimated 20 to 25 percent of these individuals have a serious mental illness, and one-half of this subgroup also have an alcohol and/or drug problem. The Budget increases services for those who are homeless or at-risk of being homeless by more than \$6 million. Through the PATH program, SAMHSA will expand outreach, screening, mental health, drug treatment, and other needed services to homeless or those at risk of becoming homeless.
- Many people who are incarcerated have behavioral health disorders: studies indicate that between 16 and 50 percent of all incarcerated individuals have mental illnesses, and up to 80 percent have a substance use problem. The Budget increases services for this population by \$30 million through the SAMHSA drug treatment courts. SAMHSA drug and mental health treatment courts provide the essential mental health and substance abuse services, housing, vocational, and employment services needed to break the cycle of abuse. The Department of Justice drug courts typically provide money to establish and or enhance the operational activities of the drug court itself; however, a very small percentage if any, of these funds are used for treatment services for drug court participants. SAMHSA drug courts provide the essential mental health, substance use and recovery support services connected with a counselor or case manager who is looking at the comprehensive needs of the individual.
- We know that nearly one-fourth of all stays in U.S. community hospitals for patients age 18 and older—7.6 million of nearly 32 million stays—involved depressive, bipolar, schizophrenia, and other mental health disorders or substance use related disorders in 2004, according to a new report by HHS' Agency for Healthcare Research and Quality.
- Lost productivity due to mental illnesses impacts the corporate bottom line. A recent study published in the American Journal of Psychiatry estimated that 96.2 million lost workdays and \$14.1 billion in salary-equivalent lost productivity per year associated with bipolar disorder and 225.0 million workdays and \$36.6 billion in salary-equivalent lost productivity per year associated with major depressive disorder.
- And, most illicit drug users are employed. Of the 17.9 million current illicit drug users aged 18 or older in 2006, 13.4 million (74.9 percent) were employed either full or part time. The same is true for heavy alcohol users. Among 16.3 million heavy drinkers, 12.9 million (79.2

percent) were employed. To address workplace and other emerging prevention needs, including alcohol abuse prevention, identified by State and local communities the Budget includes \$7 million within the Prevention Programs of Regional and National Significance.

- If we are to move ahead of the curve, move “upstream,” we have to help America’s young people before they “fall in the river” - become involved with drugs and alcohol – we need to start very early in life, before mental health problems become chronic, debilitating conditions. Lessening, and in many instances negating, the need for services in the first place through promotion of mental health and well-being and the prevention of mental illness. The FY 2009 Budget focuses on what works and on activities that have demonstrated improved health outcomes so that we can continue to move “upstream.”
- In terms of moving “upstream” to prevent young people from “falling in the river” there is some good news I would like to share - as a Nation we are making progress. According to the Monitoring the Future Survey, trends of decreasing drug use have continued among young people from 2001 to 2007:
- Use of any illicit drug has dropped 24 percent;
- Marijuana use has decreased 25 percent; and, use of methamphetamine has plummeted a staggering 64 percent.
- Use of alcohol, including binge drinking, and cigarette smoking have decreased by 15 and 33 percent, respectively.
- These trends are to be celebrated and are to be credited to the work of grass roots community coalitions, parents, teachers, youth, employers, and religious leaders. The most important work to reduce drug use is done in America’s living rooms and classrooms, in churches and synagogues, in the workplace, and in our neighborhoods. However, our work is far from done.
- Last October, SAMHSA released a new, first-of-a-kind report titled, A Day in the Life of Adolescents: Substance Use Facts, highlighting the substance abuse behavior activities that occur among adolescents on an average day in America. This SAMHSA report presents a stark reminder of the daily toll substance abuse takes on America’s young people.
- Among the report’s major findings is that on any given day during 2006, nearly 1.2 million adolescents aged 12 to 17 smoked cigarettes, 631,000 drank alcohol, 586,000 used marijuana. In addition, each day nearly 50,000 adolescents used inhalants, 27,000 used hallucinogens, 13,000 used cocaine, and 3,800 used heroin.
- The report also sheds light on how many adolescents ages 12 to 17 used illegal substances for the first time. On an average day in 2006:
- Nearly 8,000 adolescents drank alcohol for the first time;

- Approximately 4,300 adolescents used an illicit drug for the first time;
- Around 4,000 adolescents smoked cigarettes for the first time;
- Nearly 3,600 adolescents used marijuana for the first time; and
- Approximately 2,500 adolescents abused pain relievers for the first time.
- By breaking the data down and analyzing it on a day-to-day basis, we gain a fresh perspective on the challenge before us in the years to come and the importance of our efforts.
- While substance abuse prevention is critical it's not enough. We must also focus on mental health promotion and mental illness prevention. The FY 2009 Budget includes \$7.3 million for a new Targeted Capacity Expansion activity within the Mental Health programs of Regional and National Significance to address emerging mental health needs identified by States and local communities.
- One tool available to States and Communities as they assess and address current and emerging needs is a report SAMHSA recently submitted to Congress titled Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Resilience. The report begins by describing the public health context for promotion of mental health and the prevention of mental disorders in children. Then it focuses on research-based prevention and wellness efforts that provide parents tools to enhance child resilience in the face of adversity. And, it talks about the significant impact of these adverse situations can have on children's mental health.
- With all of our reports in hand, research findings that have produced life saving treatments, and service demonstration programs that have produced best practices and evidenced-based practices – how do we get ahead of the curve or move “upstream?”

Public Health Approach

- If we are serious about addressing the challenges we must continue to transform our health care system. Stigma and a long list of other barriers have kept mental health care and substance abuse treatment and prevention on the margins of the public health and healthcare delivery system.
- Our very approach to healthcare in the U.S. is based on the treatment of acute- and chronic-conditions. It rewards and provides incentives for treating conditions rather than preventing them.
- And, increasing pressure to provide medical care for the indigent and uninsured have seriously eroded the capacity of state and local public health agencies and organizations to fulfill their basic community-wide responsibilities.
- We must continue to move towards a more balanced approach that supports service delivery

at each point on the continuum of care for an increasingly diverse population – from public health promotion and disease prevention through the treatment and management of serious acute and long-term chronic illnesses to the adoption of recovery model as the expectation in behavioral healthcare.

- Programs such as SAMHSA’s Access to Recovery (ATR), exemplifies the new recovery paradigm. While expanding system capacity, supporting client choice, and increasing the array of faith and community based providers, ATR has reframed public policy from being limited to providing access to treatment to one focused on helping individuals attain and sustain recovery in the most meaningful way. All together, we’ve helped over 199,000 individuals through this program and surpassed the program goal of 125,000 by 74,000. Our goal is to serve a total of 160,000 clients over the next three years.
- However, our reliance on treating health conditions after they have become a problem is not sufficient to advance the health of the nation, particularly when it comes to behavioral health.
- To take advantage of the opportunities at hand, we must change the paradigm on which behavioral health care is based. We must work both “upstream” and “downstream,” emphasizing connections: across disciplines to create a larger context for the care of the whole person; with primary care practitioners and behavioral health providers to look beyond their individual disciplines to integrate historically independent and isolated disciplines; and, among the scientific community and the broader public and between the substance abuse prevention and treatment and mental health service community and consumers.
- The public health approach represents the next step toward full integration of behavioral health care into national health policy and program.

Integrated Care

- Integration is key to the public health approach. This “upstream” approach recognizes that behavioral health is inextricably linked to overall health and that integration is valuable and necessary. That is why I am so passionately convinced that mental illnesses and substance use disorders should be and must be treated with the same urgency as any other health condition.
- One way to accomplish this goal of service integration is to strengthen the relationship with primary care providers. Primary care practitioners have access to a large segment of the population. We need to take behavioral health service to the people where they are and not wait until they are in crisis. By encouraging health care professionals to identify at-risk populations and intervene early, we can significantly reduce the burden of substance abuse and mental illness among Americans and our social institutions.
- For example in 2006, Health Resources and Services Administration (HRSA) funded more than 4,000 health center sites that served more than 16 million low-income patients around the country. Since 2001, health center sites have seen a 170% increase in the number of patients receiving mental health care, from 176,000 to an estimated 470,000. During this

time period, health center sites have also reported a 20% increase in the number of patients receiving substance abuse services, from 76,000 to an estimated 92,000.

- We are working on building strategic alliances to identify individuals developing substance use and mental disorders early on and to ensure the latest services and supports are being provided to those served in HRSA funded health clinics. Given the linkage between substance abuse and infectious diseases like HIV and hepatitis, SAMHSA is also working with the Centers for Disease Control and Prevention (CDC) to ensure that rapid HIV testing is incorporated into programs that are reaching at-risk clients.
- While several models of primary health care and behavioral health care integration exist, one particularly useful model focuses on behavioral health screening through primary care. Numerous reliable, valid screening instruments for mental and substance abuse disorders are available for application to the general population or to a targeted population, either as stand-alone assessments or within a general health questionnaire. Ultimately, when such screening is provided as part of a primary care assessment, we can intervene early and ensure individuals receive appropriate treatment and recovery supports.
- For example, SAMHSA has awarded Screening, Brief Intervention, Referral, and Treatment (SBIRT) grants to help identify individuals with emerging or undiagnosed substance abuse problems. These grantees have implemented SBIRT in trauma centers/emergency rooms, community clinics, federally qualified health centers, and school clinics. These programs provide screening and effective strategies for intervention before the individual needs more extensive or specialized treatment. According to the latest data available, SBIRT grantees have screened more than 545,465 individuals. Among those at-risk, high-risk, or severe-risk for substance abuse problems individuals who received a screening and intervention, 62 percent reported stopping drug use and 60 percent reduced their alcohol consumption to low-risk levels. Preliminary SBIRT data also show a total of 74 percent of high-risk individuals reported lowering their drug or alcohol consumption after one or more brief treatment sessions, and 48 percent reported stopping use.
- Another step forward in support of screening comes from the American Medical Association. Recently, the AMA introduced new healthcare codes for substance abuse screening and brief intervention in its Current Procedural Terminology (CPT), which took effect January 1, 2008. These new codes provide a mechanism for health care professionals to be reimbursed for using these highly effective tools. The codes will increase the likelihood that those with substance abuse problems receive an appropriate intervention before developing a disorder, and those with a disorder will be linked to appropriate treatment and recovery support services.
- The Center for Medicare and Medicaid Services has also recently approved “HCPCS” codes to reimburse for Screening and Brief Interventions under Medicaid. Those codes now need to be implemented on a state-by-state basis for early screening and intervention for substance use disorders.
- These changes are exciting; they signal a meaningful shift in how substance abuse is being

viewed by those in general health care, in health policy, and in health care reimbursement.

- The application of what we know about public health, screening and early intervention and the integration of health services is a much more rational approach for the allocation of scarce resources. By moving upstream and by integrating care across disciplines – particularly among primary care providers – chronic disease can be prevented, health care costs can be reduced; the toll taken by excess disability that arises when diagnosis and treatment come later along the health-illness continuum can be lowered.
- Behavioral health is inextricably linked to overall physical health, and integration is valuable and necessary to advance the health of the Nation.

Working Smarter

- Changing the health care paradigm will not happen overnight. In the meantime, we must make certain that what we do with our resources is as effective and efficient as possible. And, we must be smarter about what we do. We must continue to keep working to bring new knowledge and new technology to daily community-based practice.
- With the explosion of scientific advances, new treatments, breakthroughs in promoting health, and medical information, perhaps the most important advance in health and well-being may be the public health applications of technology.
- SAMHSA is working to harness the power of emerging technology to help enhance communication among consumers, health care professionals and community-based services. Advanced communication and information technology will empower consumers and families allowing for self-management of care, and electronically linking multiple service systems. Providers will access expert systems that bring to bear the most recent breakthroughs and studies for determining the best care options and evidence-based practices.
- Through technology and training we must continue to keep working to bring the new knowledge, treatments, cures and preventive strategies developed by our research institutes to daily community-based practice.
- With the rapid growth in the identification of evidence-based practices over the past decade and to help close the science and service gap, SAMHSA created the National Registry of Evidence-based Programs and Practices, called NREPP. NREPP is a web-based decision support system designed to help States and community-based service providers make informed decisions about interventions they select to prevent and treat mental and substance use disorders.
- The NREPP system is the culmination of a multi-year process that included input from numerous scientific and health care service experts and the public. It currently provides information on approximately 170 interventions and another 120 interventions are in the queue for review.

- As investments in research provide evidence of effectiveness of new interventions, SAMHSA will continue to support the acceptance and adoption of evidence-based interventions through requirements in services grants and training. The Budget increases NREPP by more than 60 percent over the 2008 Enacted level.
- To ensure that the public, consumers, recovery community, and service providers are aware of the latest information, prevention interventions, treatments, and recovery support services, SAMHSA operates its Health Information Network (SHIN).
- The Network receives over 50,000 direct contacts – people writing, calling, e-mailing - a month with a variety of requests.
- Requests range from moms and dads looking for information on how to talk with their children about drugs and alcohol, and people looking for substance abuse treatment or mental health services for themselves or loved ones, to service providers seeking the latest information on effective treatments and recovery support services. The President's Budget maintains funding for these SHIN activities.
- Working smarter also means being sure that we are effective in what we do. That's why the FY 2009 budget promotes the use of science-based, effective program models by its grantees, and supports training and technical assistance centers, including Addiction Technology Transfer Centers, the Centers for the Application of Prevention Technology and many specialized mental health centers, that help to develop the workforce capacity to deliver the latest in behavioral health services.
- SAMHSA has also instituted a series of national and state outcome measures – realistic measures of success in substance abuse treatment and prevention and mental health services – that are gauging whether we're getting the best "bang for the buck" in our block and discretionary grant programs. While many states have been voluntarily reporting on selected outcome measures since FY 2002, not all States are reporting on these measures. The proposed budget increases the Substance Abuse Prevention and Treatment Block Grant by \$20 million to create a financial incentive for States to report on National Outcome Measures (NOMs) and to expand capacity. These funds will continue to provide the flexibility that is currently available under the SAPT Block Grant. The supplemental awards may be used to expand capacity or invest in treatment services or data infrastructures. NOMs track and measure meaningful, real life outcomes for people in recovery from mental illness, addiction and/or co-occurring mental and substance use disorders and for prevention and early intervention.
- With these measures, we will be able to report consistent, cross-year data allowing us to examine the impact of programs and changes over time. It not only makes sense to keep Congress and taxpayers informed on the effectiveness of their investment in our programs, but it also helps assure that we are providing the best services and achieving the best possible outcomes.

Conclusion

- Mr. Chairman and Members of the Subcommittee I'm optimistic. We have never before known so much about the prevention and treatment of mental illnesses and substance use disorders. We have a rich history that has guided us – pointedly describing our failures, and at the same time illuminating a path to improvement, and ultimately to success – “a life in the community for everyone.”
- I look forward to the day when we do what we know, and when mental illness and substance abuse are treated with the same urgency as other illnesses. I look forward to the day when a public health model ensures that preventing illness is as much a priority as treating illness when it arises, and when we have policies and systems that build resilience and facilitate recovery. Then, and only then, will we have a truly healthy and rich nation.
- Thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

Terry Cline, Ph.D., Administrator
Substance Abuse and Mental Health Services Administration
United States Department of Health and Human Services

Terry Cline, Ph.D., was nominated by President George W. Bush on November 13, 2006 and confirmed by the U.S. Senate on December 9, 2006 as Administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA). As SAMHSA Administrator, Dr. Cline reports to Health and Human Services Secretary Michael O. Leavitt and leads the \$3.3 billion agency responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions treatment, and mental health service delivery systems.

Throughout his career Dr. Cline has worked to ensure individual and family needs are the driving force for the prevention, treatment and recovery support services delivered. He has championed the principle that mental health and freedom from substance abuse are fundamental to overall health and well-being and that mental and substance use disorders should be treated with the same urgency as any other health condition.

Prior to his appointment as SAMHSA Administrator, Dr. Cline put these core values to work as Oklahoma's Secretary of Health, a position he was appointed to by Governor Brad Henry in 2004. At the same time, he served as Oklahoma's Commissioner of the Department of Mental Health and Substance Abuse Services, a position he held since January 2001. He actively participated in and supported the creation of grassroots coalitions to improve the health status of local communities. During his tenure in Oklahoma, Dr. Cline built strong collaborative relationships among the multiple constituency groups and government agencies that touch the lives of people with substance abuse and mental health problems.

As a result of these partnerships significant advances were made in transforming the State's service delivery systems, including the creation of Oklahoma's Integrated Services Initiative which creates a holistic approach to treatment needs, a wide expansion of drug courts throughout the State and the introduction of mental health courts into Oklahoma along with a Statewide focus on recovery and recovery support services.

Dr. Cline has extensive experience in overseeing health and human services at the State level. He has also served as a provider through an earlier post as the Clinical Director of the Cambridge Youth Guidance Center in Cambridge, Massachusetts and as a Staff Psychologist at McLean Hospital in Belmont, Massachusetts. His professional history also includes a six-year appointment as a Clinical Instructor in the Department of Psychiatry at Harvard Medical School and Chairman of the governing board for a Harvard teaching hospital in Cambridge, Massachusetts.

A native of Ardmore, Oklahoma, Dr. Cline attended the University of Oklahoma where he earned a bachelor's degree in psychology in 1980. He then received both a master's degree and a doctorate in clinical psychology from Oklahoma State University. Dr. Cline has involved himself in community service, including membership on a number of local, State and national committees and boards with a focus on improving the overall health of the community and the Nation.

Department of Health and Human Services
Office of Budget
Richard J. Turman

Mr. Turman is the Deputy Assistant Secretary for Budget, HHS. He joined federal service as a Presidential Management Intern in 1987 at the Office of Management and Budget, where he worked as a Budget Examiner and later as a Branch Chief. He has worked as a Legislative Assistant in the Senate, as the Director of Federal Relations for an association of research universities, and as the Associate Director for Budget of the National Institutes of Health. He received a Bachelor's Degree from the University of California, Santa Cruz, and a Masters in Public Policy from the University of California, Berkeley.

Mr. OBEY. Thank you.

We are halfway into a vote on the House floor. So I think we had best recess at this point, go over and vote and then come right back. We will then hear from Dr. Clancy.

[Recess.]

Mr. OBEY. Dr. Clancy.

AHRQ'S MISSION

Dr. CLANCY. Mr. Chairman, members of the Committee, I am honored to be here today.

As you may know, AHRQ's mission is to improve the quality, safety, efficiency and effectiveness of healthcare for all Americans as shown on this slide. So our mission is driven by the needs of people who use the research: patients, clinicians, health system leaders and policy-makers.

A major focus for us is translating findings of our research into practice and policy, and to that end we work very closely with the organizations directed by my colleagues here. We also work as a science partner to CMS and have had the opportunity to collaborate with the VA and the Department of Defense as well.

The next slide just demonstrates that while our research agenda is broad and spans promoting healthcare information technology to reducing medical errors to supporting comparative effectiveness to enhancing Americans' healthcare quality that they get right now. This map just shows that we have a broad geographic reach.

COMPARATIVE EFFECTIVENESS RESEARCH

Today, I would like to highlight first for the Committee our work in the area of comparative effectiveness research which has been the subject of a great deal of interest recently.

Under the MMA, AHRQ was authorized to conduct and support research with a focus on outcomes, comparative clinical effectiveness and appropriateness of pharmaceuticals, devices and healthcare services. The focus of this research is based on the top 10 conditions that are common and costly for those whose healthcare is funded by Medicare, Medicaid and S-CHIP programs. The list of priority conditions shown in the written statement was developed with substantial input from the public and private stakeholders.

Since 2005, we have released 14 comparative effectiveness reviews. These reviews range from diagnostic evaluation of technologies for abnormal breast cancer screening to comparative effectiveness of drugs for depression to treatments for prostate cancer.

As one example, one review found that drugs can be as effective as surgery for management of gastroesophageal reflux disease, better known as heartburn. This turns out to be one of the most common health conditions in older Americans and results in \$10,000,000,000 annually in direct healthcare costs.

Among the other topics are treatments for localized prostate cancer, a decision that many men and their providers are facing every day, as well as examining the benefits and harms of all oral medications for patients with Type 2 Diabetes.

We place a great deal of value in ensuring that our work is credible and scientifically sound, and we have made investments to

make sure that the methods and processes for performing comparative effectiveness research are of the highest quality.

We are very excited that our comparative effectiveness research is now being increasingly used by the Consumers Union in their Best Buy Drugs project and in other reports on health treatments. The National Business Group on Health is also making this research available to employers and their employees.

I think that you are all aware how excited the CBO has been about the possibility for comparative effectiveness research to give us better evidence about which treatments work for which patients. Their report further suggests that this research can help reduce healthcare spending and improve quality and value.

The bottom line, actually, is that doing the right thing for the right patient at the right time, using comparative effectiveness research to improve the quality of healthcare will enhance the value of our investments in healthcare.

I want to thank you and the Committee for allowing us to double our investment this year from \$15,000,000 to \$30,000,000. We expect to double the number of reviews and technical briefs and so forth.

HEALTH INFORMATION TECHNOLOGY

But it is very important to recognize that simply better research is not necessarily going to translate into better value. We have to be anticipating up front how this information will be used and how it can be immediately available to clinicians and patients when they are confronting tough decisions right now.

So that is why the research investments that we have made in the use of health IT to improve healthcare right now are particularly important. They will allow health information technology and electronic medical records to gather better information to do future reviews and to also serve as a platform for putting that information into the hands of clinicians and patients now.

Technologically, we know how to do this. When I logged on to Amazon not too long ago, they helpfully reminded me that Bruce Springsteen had a new CD out and they did not tell me that Britney Spears had any new work for me to be interested in.

Technology is not the hard part. The hard part is having good content that clinicians and patients need today. We know that health IT is not a magic bullet.

PATIENT SAFETY

I wanted to also just highlight for you some very important work we did in patient safety to give you a sense of the successes we have had. We supported a project at Johns Hopkins University which worked with all the hospitals in Michigan to implement a very simple checklist to reduce serious infections for patients in ICUs. Many of these hospitals were actually able to reduce that infection rate to zero.

I heard a healthcare leader, not too long ago, refer to this as one of the most important developments in a generation. What he meant by that was when he and his colleagues were providing ICU care, they always thought that these infections were very tragic but unavoidable, part of the ticket price of admission for getting inten-

sive care. Now this study was able to show that, in fact, they are almost totally avoidable and in some cases can be eliminated altogether.

I wanted to also mention that very recently in the New England Journal, there was a terrific article called Eulogy for a Quality Measure. The title comes from the fact that it has now become such routine practice to give patients who have had a heart attack a drug called a beta blocker which reduces subsequent mortality. It happens so routinely now, which has not always been the case, that we no longer have to track it in quality report cards.

This is a success story and suggests that measurement and public reporting is a good idea. That is the good news.

The slightly less good news is the people actually did the landmark trial 25 years ago when I was a resident, and I think we can and have to move much, much faster to translate the investments that the taxpayers have made in scientific research into the healthcare that people get right now. I think investments in our essential programs will be pivotal to actually making that translation happen.

Thank you very much.

[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Health Issues and Opportunities at AHRQ

Witnesses appearing before the
House Subcommittee on Labor-HHS-Education Appropriations

Carolyn Clancy, M.D.
Director, AHRQ

Accompanied by:

Richard Turman
Deputy Assistant Secretary, Budget

March 5, 2008

Introduction

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss with you health issues and opportunities at AHRQ. As you may know, AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. We do this by supporting research to improve the quality of health care, reduce its cost, improve patient safety and address medical errors, Our mission is driven by the needs of the people who use our research -- patients, clinicians, health system leaders, and policymakers. A major focus for us is to translate the findings of our research into practice and policy. We work closely with our partner agencies in Department of Health and Human Services to achieve this objective.

The agency's research agenda is broad and spans from promoting health care information technology to reducing medical errors; from supporting comparative effectiveness research to enhancing Americans' health care quality.

Today, I would like to first highlight for the Committee our work in the area of comparative effectiveness research, which has recently received a lot of interest.

Comparative Effectiveness Research

Mr. Chairman, AHRQ was authorized to perform comparative effectiveness research under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. MMA authorizes AHRQ to conduct and support research with a focus on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. The focus of this research is based on the top ten conditions (*see table*) that are common and costly among those whose health care is funded by Medicare, Medicaid, and the State Children's Health Insurance Program. The list of priority conditions was developed with substantial input from the public and stakeholders.

The comparative effectiveness research program was established using an existing infrastructure of our Evidence-based Practice Centers and created capacity for rapid-cycle comparative effectiveness research, and translation of comparative effectiveness findings for patients, clinicians, and policy makers.

10 Priority Conditions for Comparative Effectiveness Research

- Arthritis and non-traumatic joint disorders (Muscle, bone, and joint conditions)
- Cancer (Cancer)
- Chronic obstructive pulmonary disease and asthma (Breathing conditions)
- Dementia including Alzheimer's disease (Brain and nerve conditions)
- Depression and other mood disorders (Mental health)
- Diabetes mellitus (Diabetes)
- Ischemic heart disease (Heart and blood vessel conditions)
- Peptic ulcer disease and dyspepsia (Digestive system conditions)
- Pneumonia (Breathing conditions)
- Stroke and hypertension (Heart and blood vessel conditions)

Since 2005, the Effective Health Care Program has released 14 comparative effectiveness reviews. These reviews ranged from diagnostic evaluation of technologies for abnormal breast cancer screening to comparative effectiveness of drugs for depression to treatments for prostate cancer. As an example, one review found that drugs can be as effective as surgery in the management of gastro esophageal reflux disease (GERD), better known as heartburn. GERD is one of the most common health conditions in older Americans and results in \$10 billion annually in direct health care costs.

We are beginning to see an impact from AHRQ's comparative effectiveness research. It is used by a variety of groups who make decisions about health care. For example, *Consumer Reports Best Buy Drugs*, a public education project of Consumers Union, uses these findings to help health care professionals and patients determine which drugs and other medical treatments work best for certain health conditions. The National Business Group on Health uses this research to provide employers and their employees' best available evidence for designing benefits and making treatment choices. Medscape, an online medical information and education tool for specialists, primary care physicians, and other health professionals, uses the reports for clinicians to get continuing education. In addition, most of the reports are published concurrently in one of the *Annals of Internal Medicine*, one of the premier medical journals.

A recent Congressional Budget Office report indicates that only a limited amount of evidence is available about which treatments work best for which patients and whether the added benefits of more-effective and more-expensive services are sufficient to warrant their added costs. The CBO report suggests that comparative effective research could help reduce health care spending without affecting health overall. The bottom line is that "doing the right thing" – using comparative effectiveness to improve the quality of health care – will enhance the value of our investments in health care.

Mr. Chairman, I would like to thank the Committee for its continued support for comparative effectiveness research, and in particular, for doubling the Agency's funding in this critical area from \$15 million to \$30 million in FY 2008. With this increase the number of comparative effectiveness reviews and technical briefs, and other products will double. New research studies will include surgical interventions, prescription drugs, heart disease, infectious diseases, and obesity. Continued investments in comparative effectiveness research at AHRQ will help us fill the evidence gap identified by CBO and provide better health care value for Medicare beneficiaries and all Americans.

Health Information Technology

However, simply producing comparative effectiveness research isn't sufficient to improve the quality and value of health care services. Creating the means and capacity will put the findings of research quickly at the fingertips of health care professionals and patients. For that, we need "smart" health IT, health information technology

AHRQ's unique contribution to health information technology (health IT) is a key element in achieving this goal and bringing to health care into the 21st century. Since 2004, AHRQ has invested \$199 million in grant and contracts in 48 states to support and stimulate investment in health IT, especially in rural and underserved areas.

Increased investments in this area would foster a collaborative effort between AHRQ's health IT research and comparative effectiveness programs to develop a way of quickly and efficiently delivering the findings of research to health care professionals and patients. For example, comparative effectiveness research shows that a certain drug is best to treat high blood pressure. As soon as the health care professional enters a diagnosis of high blood pressure into a patient's electronic medical record, a prescription for that drug is generated automatically. The electronic medical record would generate a warning against using that drug if the patient is allergic or shouldn't take it for some other reason. In this case, it would offer alternatives. Similarly, the same system can collect information on unexpected patient harms to patients from treatments.

We also would work to create a system that would, with the right Federal, State, and private sector partnerships, help implement electronic prescribing throughout the health care system in a way that improved quality, rather than the haphazard way that it is currently occurring.

Health IT has breathtaking potential to change dramatically how patients receive health care services. Currently, we need to go to a doctor's office or clinic for health care information and services that are tailored to our individual needs and preferences. Under the concept of a health IT-enabled "medical home," anywhere with a computer and Internet access – one's home, a library, a school – can be a place where people can connect with their health care providers for this type of service.

To ensure that we harness the power that health IT has to offer, we need to develop an evidence-based strategy to help clinicians and health care leaders decide which health IT innovations we should be adopted and how they should be implemented to maximize value – both to clinicians and patients today and to the public health and research enterprises.

Patient Safety

We know that health IT is not a magic bullet for improving the quality, safety and value of health care. We also need a change in the culture of health care that takes a systematic approach to eliminating medical errors and improving overall quality.

Just last month, we published a proposed rule implementing the Patient Safety and Quality Improvement Act. This proposed rule improves the quality and safety of health care for all Americans by fostering the establishment of patient safety organizations – private entities recognized by the Secretary of Health and Human Services to collect and analyze patient safety events reported by health care providers. They are new and separate from all currently existing entities that are addressing health care quality.

The new rule provides us with an opportunity for an important future investment in efforts to reduce avoidable harms to patients. With additional funding, we could accelerate the development of patient safety event reporting systems as well as other provisions in The Patient Safety and Quality Improvement Act.

Another opportunity would be for AHRQ to expand the Patient Safety Improvement Corps – a group of health care professionals from state government and hospitals especially trained in strategies to reduce medical errors. We could expand the Corps to include other professionals in a greater number of communities.

Additional opportunities exist to accelerate the development and implementation of evidence-based tools to health care professionals nationwide. This would include the development of assessment tools that could be used to gauge the culture of safety in health care settings such as dialysis centers, nursing homes, physicians' offices and free-standing clinics.

Our investments in patient safety have already shown improvements in care and have increased the commitment to patient safety in many health care settings. For example, AHRQ supported research at Johns Hopkins University that developed a program that instituted a simple five-step checklist designed to prevent certain hospital infections in intensive care units (ICU) throughout Michigan. Among other things, the check list reminds doctors to wash their hands and put on a sterile gown and gloves before putting intravenous (IV) lines into patients. As a result of taking this simple step, the rate of bloodstream infections from IV lines was reduced by two-thirds within three months. In addition, the average ICU decreased its infection rate from 4 percent to zero. Over 18 months, the program saved more than 1,500 lives and nearly \$200 million. One leader in critical care medicine described these results as one of the most important developments in a generation.

This is just one example of how our investments in patient safety have made improvements in care. We recognize that our health care system is massive, with over \$2 trillion spent annually on care, and that our investments are only the tip of the iceberg. There is a lot more that needs to be done.

Value in Health Care

Mr. Chairman, so far I have raised a number of opportunities that we see as critical steps toward improving the quality of health care. I would now like to highlight steps that we can take to help ensure that we are getting value in our investments.

As we are all aware, growth in health care costs is placing a tremendous burden on federal and state budgets, threatening employer capacity to provide health insurance, and straining personal finances. Through research that we have supported, we know that a large part of this cost can be attributed to the use of inappropriate use of resources.

In an effort to create value for our health care investments, AHRQ is supporting efforts to measure, track, and report on health care quality and how health care services are used. These efforts give us a snapshot of the health care system and show us where we need to make improvements and adjustments.

For example, through a partnership with state hospital associations and state data agencies, AHRQ's Healthcare Cost and Utilization Project or HCUP, has data on 90 percent of all the hospital discharges in the country, as well as emergency department and ambulatory data from about half the States.

HCUP provides a rich data source for Federal, State and local policy makers, as well as individual communities seeking to improve quality and reduce waste. For example, the National Institutes of Health has used the data from HCUP to determine that a questioned rotavirus vaccine was indeed safe, resulting in a go-ahead for immunizing children around the world. Also, Federal policymakers have used it to create benchmark data on influenza rates and MRSA. The future opportunity that many States see right now is linking administrative or billing data to smart HIT so that health care challenges can be rapidly identified and addresses, and State leaders can assess the impact of changes in policy on health care and people's health.

Finally, since we recognize that many value improvements require community-wide actions, we have recently launched Secretary Leavitt's Value-Driven Health Care Initiative. The ultimate goal of the Initiative is to increase value and quality of care that Americans' receive. AHRQ has recently launched 14 community- and state-wide collaboratives in 13 states. These multi-stakeholder groups will be working to track, publicly report, and improve quality across their communities. These 14 and additional communities to be selected later this year will be front-row customers for the products of comparative effectiveness research, greatly expanding the number of Americans who benefit from taxpayer-supported research investments. Clinicians and patients confront challenges in making the best decisions every day; our job is to make sure that evidence-based information is available when and where it is needed.

Conclusion

Mr. Chairman, I want to thank you for the opportunity to discuss with the Committee how continued investments in AHRQ's essential programs will improve quality and value in health care.

Thank you.

Carolyn Clancy
Director
Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Human Services

Carolyn M. Clancy, M.D., now serves as Director, Agency for Healthcare Research and Quality (AHRQ). Prior to her appointment as Director on February 5, 2003, Dr. Clancy had served as AHRQ's Acting Director since March 2002 and before that Director of AHRQ's Center for Outcomes and Effectiveness Research (COER).

Dr. Clancy is a general internist and health services researcher, and a graduate of Boston College and the University of Massachusetts Medical School. Following clinical training in internal medicine, Dr. Clancy was a Henry Kaiser Family Foundation Fellow at the University of Pennsylvania. She was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia in Richmond prior to joining AHRQ (then named the Agency for Health Care Policy and Research) in 1990.

Her major research interests include women's health, primary care, access to care, and the impact of financial incentives on physicians' decisions. She holds an academic appointment at George Washington University School of Medicine (Clinical Associate Professor, Department of Health Care Sciences) and serves as Senior Associate Editor, Health Services Research. Dr. Clancy is a member of multiple editorial boards (American Journal of Public Health; Journal of Evaluation in Clinical Practice; Journal of General Internal Medicine; and Medical Care Research and Review).

Dr. Clancy has published widely in peer-reviewed journals and has edited or contributed to five books. Her work in women's health was recognized by an award from the Women's Caucus of the American Public Health Association. Active in multiple professional organizations, she has been recognized as a leader within the Society of General Internal Medicine. Before becoming the Director of COER in 1997, Dr. Clancy served as Director of the Center for Primary Care Research. There she helped develop the U.S. Public Health Service Primary Care Policy Fellowship and led research initiatives on:

- The interface of primary and specialty care.
- The impact of health care reforms on primary care.
- The evaluation of strategies to implement clinical practice guidelines in primary care practice.

Department of Health and Human Services
Office of Budget
Richard J. Turman

Mr. Turman is the Deputy Assistant Secretary for Budget, HHS. He joined federal service as a Presidential Management Intern in 1987 at the Office of Management and Budget, where he worked as a Budget Examiner and later as a Branch Chief. He has worked as a Legislative Assistant in the Senate, as the Director of Federal Relations for an association of research universities, and as the Associate Director for Budget of the National Institutes of Health. He received a Bachelor's Degree from the University of California, Santa Cruz, and a Masters in Public Policy from the University of California, Berkeley

NIH BUDGET

Mr. OBEY. Thank you.

Let me try to ask four quick questions.

Doctor Zerhouni, I have said before that I have never had anybody come up to me in my district and say, Obey, why don't you guys get your act together and cut cancer research, and yet that is what the previous Congress and the President did. For two years, we actually reduced the number of research grants down at NIH.

This year, you have a freeze. You have indicated that that means that we will lose about 6,000 scientists. Why should the Country give a damn?

Dr. ZERHOUNI. I believe if you look at the impact of the below inflation budget, we need to understand that the capacity of our Country to react to both its current problems and its future problems will depend on a trained, committed, talented scientific workforce.

Seventy to eighty percent of our expenditures, depending on what you do, is related to people, trained scientists. It takes about 20 years to train a scientist, and it costs about \$100,000 a year.

Every time we can't sustain our purchasing power, it hits scientists primarily and especially early career scientists. This is the concern that I expressed when I said that at the end of the day, all of this impacts people.

This isn't just dollars. This is an investment in people, the people who know how to deliver better healthcare and the people who will deliver the new healthcare of the future.

GENES AND ENVIRONMENT

Mr. OBEY. One more question, there is a lot of focus on molecular biology, a lot of focus on genetic predisposition to certain diseases, and I understand that.

But I guess one of the principal critiques of medical research in this Country on the part of some would simply be that while we invest a whole lot to try to understand that end of the equation, we are not doing nearly enough to figure out what the environmental triggers for some of these problems are. What would your response be?

Dr. ZERHOUNI. I think there is truth to the fact that we need a multi-pronged approach. I think your genes are only half of the reasons why you suffer from a disease. The environment is just as important.

The fact is we have environmental measures we feel at NIH are good at a population level, but they are not good at the individual level. The medicine we are talking about is going to have to be personalized to your own genetic risk factor and to your own environment. This is why the NIH launched the Genes and Environment Initiative two years ago to look at the ten most common diseases and develop new measures of environmental exposures at the individual level.

So I agree that we need to do better in measuring both the environmental factors as well as your natural predisposition or risk profile. Both have to come together.

HOSPITAL INFECTIONS

Mr. OBEY. Dr. Clancy and Dr. Gerberding, as you know, the old maxim in healthcare is first do no harm, and yet a lot of people run into harm accidentally when they go to a hospital. I would like to ask both of you, what do you think can be done to send a message to every hospital in America that we are dead serious about their getting dead serious about doing some of the basic things that are necessary to reduce those unacceptable infection rates?

Dr. GERBERDING. I will start. First, let me thank you for asking the question because this has been my career. Hospital infections is where I started and why I came to CDC in the first place.

I think the one thing we know for sure is that if you measure this problem and you require it to be reported either within the hospital or outside of the hospital, that it will improve.

In our reporting system that we have operated for more than 3 decades, we have seen a 50 percent reduction in these infections in the hospitals that participate and in other hospitals in Pittsburgh and Michigan where the problem has been accurately measured by people who know what they are doing. We can achieve dramatic reductions in these kind of preventable patient safety issues.

But if you ignore the problem or you take a name-shame-blame approach to it, it stays underground and it is only until something tragic crops up like the case of hepatitis C virus in Nevada right now that is related to an egregious medical error, that it really comes to the light and the public understands what the true hazards really are.

So we need to measure it. We need to do the science to identify the interventions that work, and then we need to market those interventions as widely as we can and hold systems accountable for making sure that they are properly executed.

MRSA

Dr. CLANCY. Just to build on that, let me say that this year we have the opportunity, thanks to this Committee, to invest an additional \$5,000,000 squarely focused on hospital-acquired infections with a specific focus on the methicillin-resistant staphylococcus aureus (MRSA) and we will be also looking for other sources of what is happening in nursing homes and so forth.

This is very practical research, and a big focus of this research is actually going to be making sure that the conduct of the work is done in healthcare settings in such a way as that it becomes part of core practice.

You know in the hospital, if you are in the operating room and you don't wash your hands or do the correct sterile technique, virtually everyone is empowered to tell you to stop. It doesn't matter how powerful a surgeon you are, whatever. The show stops then.

You walk through those swinging doors out to the rest of the hospital and it is something like the wild west, and I think that is the approach we need for infections.

If you asked patients who have been harmed by medical care, what they want, they want three things. They want an apology. They want to know what is going to happen to them. Is this a permanent injury or will I get better? And, they also want to know

that the institution is doing everything it can to make sure this doesn't happen again to someone else next week, which happens all too often right now.

PATIENT SAFETY ORGANIZATIONS

I am very pleased that we have out for public comment the regulation from the Patient Safety and Quality Improvement Act so that by the end of this year we will have the opportunity for hospitals, physicians and many others to work with patient safety organizations. They won't get more money for this, but it will remove the fear of liability from this equation because doctors agree with the three things patients want, but they are very worried about any information generated as a result of measuring and tracking that will be used against them.

I will also say that CMS will implement, as you know, next year a plan to not pay for some types of harms done to patients, and I would say that has a lot of people's attention very squarely.

ACCESS TO HEALTHCARE

Mr. OBEY. One last question, the same question we asked this morning, if you take a look at all the programs over which this Subcommittee has jurisdiction, what are the three or four programs that you think we should most emphasize in order to increase access to healthcare?

This morning's panel indicated that outside of doing basic medical research which is the most basic of all preventive actions, they suggested that we needed more funds into outcomes research, into State risk pools, into community health centers and in professional training, all to get us ready for the day when we do have universal healthcare.

What would your response be to that question, whomever?

Dr. ZERHOUNI. I think there are several factors that you will need to address to improve access to healthcare.

If you look at the statistics, I think my colleague was mentioning statistics in terms of how much we pay and what we receive in terms of healthcare, levels of healthcare and performance. We do spend quite a bit more than equivalent countries. If you look at our expenditures relative to Germany, we spend 50 percent more than Germans, and it is hard to see where you would have a public health general population advantage.

We do have better acute care and top-notch facilities that provide care that could not be achieved elsewhere.

So, first is cost. Access is proportional to cost. If it is too costly, people cannot access care.

The second is, in my view, to take into account the fact that medicine has to move from curative large facilities to a much more pre-emptive participatory type of medicine where community implementation of appropriate programs is going to be key to maintaining the health of the population.

I think this shift to more dispersed facilities with modern technologies including health information technologies, with easy access to patients and communities and participatory approaches is the key to making sure that at the end of the day, you don't end

up with an emergency room that is overwhelmed with problems that shouldn't be in the emergency room in the first place.

A three-pronged approach which finds ways to reduce costs and redistribute where healthcare is provided. At the end of the day, understand that it is not just how we improve delivery, but managing what is being delivered.

PUBLIC HEALTH APPROACH

Dr. CLINE. Just to add a couple of clarifications to those points, one would be really in shifting the incentives that we see in our systems and moving those incentives to the front end in our healthcare system in places where we know that people are beginning to struggle with their illnesses. We see very effective programs that are able to screen and provide very brief interventions for individuals at the front end of their illness cycle, and we know that the outcomes are very impressive.

So I would encourage, again, a realignment of those incentives away from the sole focus on the very, very acute level of care where someone is in crisis or in the emergency room but moving that to the front end, moving services where we find people in their natural elements. It may be school clinics. It may be other places where people are congregating on a regular basis.

For people with mental illness and people with substance abuse and addictions, we know that when we don't provide that service up-front, eventually they will bump into our systems. Huge costs associated with that are borne by the public at large. So we need to shift those incentives to the front end.

ACCESS TO CARE AND QUALITY

Dr. CLANCY. When I think about what is under the jurisdiction of this Committee, I think the key question is access to what?

Right now, what we are seeing as a result of the annual reports we submit to the Congress every year on quality is healthcare quality goes up every year 1 to 2 percent, a very small amount. The spending keeps going up in the ballpark of 7 to 8 percent. So we have a big disconnect.

Ultimately, to expand access, we have to make sure that we are getting the return that we want. So I think additional investments in research that help us identify what the highest value services and how do we provide them most efficiently is definitely going to be part of the foundation that we will need in thinking about getting to universal access to care.

Dr. GERBERDING. I would agree with Dr. Zerhouni that access is more than cost, although you have to allow for the cost to be affordable.

It is also about awareness. Many people right now have technical access to care, but they don't avail themselves of the services because they are not aware of what they need or they are distracted by other priorities in their life.

Some don't have the ability. I learned this in the AIDS clinic a long time ago. We had care for our AIDS patients, but many could simply not get on the bus and get there, or they were a mother with children and they didn't have child care or many other things

that mitigated their ability to come in and get their anti-retroviral drugs.

So true access has to embrace those broad issues.

Having said that, from the Committee's perspective, I would also hope that we would be talking about access to health and not just healthcare delivery. In that light, thinking about what can the labor and education parts of the Committee do to encourage or incentivize or, through a policy mechanism, ensure that health can happen in the workplace or in our schools or in other community settings.

Health isn't just about what happens in the healthcare delivery system, and there are lots of ideas that we have about policy mechanisms to create environments that are healthier for people or motivate people to be able to access health services in other contexts.

Mr. OBEY. Thank you.

Mr. WALSH. Thank you, Mr. Chairman.

Today, on the floor of the House, we are debating a bill that would require health insurance providers to provide for parity between physical health insurance and mental health, which is a good thing. There are obvious issues within that universe, that equation, that are difficult, but it is a goal. It is a worthy goal, and I think most of us support it.

This is not analogous, but I am looking at the budget before me: National Institutes of Health, \$29,000,000,000; CDC, \$6,000,000,000; community health centers, \$2,000,000,000; SAMHSA program level, \$3,300,000,000. We are not spending anywhere near what we are spending on physical health through government services.

I note that in every one of these categories the Administration has proposed a cut: 6 percent in the program level, 14 percent in mental health block grants, 2 percent in substance abuse treatment, 18 percent in substance abuse prevention, and there is also a proposed cut in homeless programs. We all know that most homeless people have a substance abuse problem of some sort.

You made a very compelling statement at the beginning of this testimony, Dr. Cline, about walking past 15 families to get to 1. You are going to be walking past 17 or 18 families at this rate to get to that 1. Would you care to comment on the disparities here?

SUBSTANCE ABUSE AND MENTAL HEALTH HEALTHCARE NEEDS

Dr. CLINE. Thank you for the opportunity.

Today, in our country, we have 23.6 million people who are in need of substance abuse treatment and currently about 2.5 million individuals who are receiving treatment at a specialty clinic.

When we look at mental health and the need on the mental health side, we have about—

Mr. OBEY. Would you repeat that number?

Dr. CLINE. Twenty-three million, six hundred thousand who are in need and two million, five hundred thousand who are actually receiving treatment from a specialty clinic.

On the mental health side, we have about 24.9 million individuals who are in need of services and about half of those individuals are receiving treatment.

One of the findings that came out of the President's New Freedom Commission on Mental Health was that our system basically is fundamentally broken. We need to completely transform our system. It is not about adding a few more programs here, adding a few more programs there. We need to radically transform the way these services are delivered.

As someone who grew up in this system as a psychologist, I can tell you, there was a time when we were very, very much on the margins of the healthcare system, if involved at all. We were certainly on the margins of the public health system, very much isolated, very much on our own.

There may be developmental reasons that took place in terms of the field finding its own identity and putting its feet on the ground as a discipline. However, that has come at a significant cost, being isolated and marginalized from the rest of the system.

So what we are proposing is that integration, that cross-fertilization take place wherever possible because we have paid an incredible cost by being at the edges of the system.

And, as a result of that, in the majority of States that you will visit and the majority of programs that you will visit, we are not talking about a healthcare system, we are not talking about a behavioral health care system. We are really talking about a crisis management system that is entirely reactive. You need to be very, very ill to be eligible for most services in most States.

The equivalent, if you were in the healthcare system—I have used this example before—would be that you would go to your primary care physician, and complain about having pains in your arm and shortness of breath and dizziness and profuse sweating. The doctor would tell you to come back after you had a heart attack.

That is what we have done in the mental health and in the substance abuse system. Wait until you are incredibly ill before you are eligible for those services.

So we need that fundamental shift to be able to move to the front end, to completely transform. Tweaking it around the edges simply will not get us there. The gap is so huge at this stage.

Mr. WALSH. Do you have a proposal?

MENTAL HEALTH PROMOTION AND PREVENTION

Dr. CLINE. Well, that proposal is to focus on early intervention. As part of our budget proposal, we are proposing an increase to the Children's Mental Health Services Program.

We just recently directed a report to Congress that is focused on promotion and prevention in mental health, strengthening resiliency, strengthening parenting and enhancing resiliency. Those were concepts that were alien to this field only five or ten years ago, the idea of prevention and promotion in mental health.

So we are moving radically in that area, but again it takes that complete transformation.

One of the things that has taken place, again as a result of the President's New Freedom Commission on Mental Health, is a Federal executive steering committee which is made up of representatives across nine different cabinet levels in the Federal Government, where all of those representatives of the agencies are coming

together with a specific focus on behavioral health as it affects all of these different areas and looking at those areas.

Mr. WALSH. If I could because time is limited, those are all worthy goals, but you can't get there, going backwards on your funding. It is pretty simple.

Just one thought, at our veterans hospital in Syracuse, there is an agreement between the hospital and the psychiatric community that everyone who goes for any level of treatment will get a holistic examination, physical and mental health.

It is unusual, it is unique, and it is a pilot program. But I think it will be very interesting to see what is determined by that program, and it may have applications for the broader society.

Thank you.

Dr. CLINE. Sounds like a wonderful program. Thank you.

Mr. OBEY. Thank you.

Just to back up what Mr. Walsh is talking about, mental health treatment and prevention, cut \$127 million, substance abuse prevention cut by \$36 million. That is like scoring a home run by going to third base first. It doesn't work very often that I have seen.

Who is next?

VACCINE FOR CHILDREN

Ms. ROYBAL-ALLARD. Dr. Gerberding, the Vaccines for Children program has been admittedly successful and, for the most part, childhood immunization rates in the United States are enviably high. However, CDC recently released new data on immunization rates showing that adults continue to be woefully under-vaccinated.

Given the fact that approximately 50,000 adults die from vaccine-preventable diseases each year, in your opinion, what are the major barriers to adult immunization?

Dr. GERBERDING. There are several different barriers, and I should mention in the same breath adolescent immunization which is also extremely challenging, now that we have these wonderful new vaccines for adolescents, but we don't have the kind of structured system for delivering them.

One barrier, obviously, is that patients don't have a uniform medical record and don't understand when and how many and how often their vaccines should be delivered. So one is a patient barrier.

A second is a system barrier where absent appropriate health information records that travel with the patient from point to point. It is impossible to really keep track of who has been vaccinated when vaccines are due or what vaccines are needed.

There are also issues around access to care and cost, co-payments and so on and so forth. We are seeing with the influenza vaccine, where we have an excellent reimbursement rate for Medicare patients and an excellent system for delivering it, that we still have individual barriers for people just deciding they don't want to get their vaccine for whatever reason even when they know they should have it and they have access to it.

So a lot of work needs to be done in this area to really achieve the promise.

We monitor influenza vaccine because it is the easiest to keep track of, but when we really assess adult vaccines across the board,

it is a missed opportunity to really save lives and save hospitalization. So it needs to be a higher priority.

Ms. ROYBAL-ALLARD. Given the success of the Vaccines for Children program, what are your thoughts of having a Vaccines for Adults program that would give poor and uninsured American adults access to lifesaving vaccines?

Dr. GERBERDING. Well, I think we need systems that not just deliver a vaccine here and there, but actually track and monitor people over the course of the many places where they receive health services.

So I actually think one of the major missing pieces to accomplish what you are suggesting is a health information record or at least a vaccine record. This record may start when you are zero years old but stays with you throughout your lifetime so that wherever you are, you know what you need and anyone can easily identify that.

We have adults with many points of contact with the system, but you may not recognize that this would also be a good time to give you your tetanus shot or your flu shot or your pneumococcal vaccine or whatever else it is that you need. We just have too many missed places because providers can't put their hands on the information that would tickle them to know what they need to do.

Ms. ROYBAL-ALLARD. Well, given a recent survey that has shown that few Americans really know what it is that they need, what would your thoughts be about having an adult immunization media campaign to raise awareness?

Dr. GERBERDING. I would love it. I would absolutely be thrilled to be able to do that.

I think it is a well-known fact at any age group that vaccines are cost-saving, not just cost-effective but cost-saving. It is one of the best investments we can make in health and to have the capacity to really create an exciting campaign, a full court press in a comprehensive and holistic way, would just be terrific.

UNDERINSURED CHILDREN

Ms. ROYBAL-ALLARD. Just one more question on immunization, as we discussed, the children's vaccine program has had remarkable success, providing uninsured and underinsured children with lifesaving vaccines at no cost.

However, there is a problem because while uninsured children can get these vaccines in multiple locations, underinsured children can only get these vaccines at federally-qualified health centers. This limitation has made it very difficult and sometimes impossible for many underinsured children to get vaccines.

Should we not be opening it up so they can get their vaccines at any public health clinic?

Dr. GERBERDING. Absolutely, and we have tried to promote some changes in the language that allows underinsured children to have this kind of access, but we also got clarification from Congress that the intent of Congress in their existing legislation was to allow us to declare public health departments and similar entities as federally-qualified venues so that we could deliver these vaccines to these children in these environments.

So we are seeing more States now take advantage of this interpretation, and we are trying to promote all of them to do this so that these underinsured kids are no longer missed in the system. It is a critical gap, and it needs to be solved.

Ms. ROYBAL-ALLARD. So do States need to be made more aware then about this possibility? That is what we need to do about that?

Dr. GERBERDING. Yes. Exactly, and we have worked with the Association of State and Territorial Health Officials, ASTHO, to try to get the word out.

We have been working with Congressman Waxman on this to make sure that we were not misunderstanding congressional intent, but we got a strong clarification that the intent was that we would be able to provide these through federally-qualified health facilities that weren't previously designated that way.

Ms. ROYBAL-ALLARD. Thank you.

Mr. OBEY. Mr. Regula.

BUILDING AND FACILITIES

Mr. REGULA. Dr. Gerberding, I am particularly interested in the way you have invested a great deal of taxpayer dollars in the improvement of the CDC facilities in Atlanta. Please share with us the status of facility construction on the campus and how these improvements are improving CDC service to people.

Dr. GERBERDING. Thank you for asking the question.

As you know, my predecessors for many years engaged in a buildings and facilities improvement planning process at CDC, and we were able to accelerate a 10 year plan into a 5 year plan.

We are not done yet with the master plan, but we have made such extraordinary progress that I don't think you would recognize the CDC from your last visit. I know the Committee has visited the CDC a while back, and it would be unrecognizable to you today. It is a beautiful campus.

Our laboratories are now safe. They are modern. They are well-equipped. We have more to go in terms of getting them all rehabilitated, but it is a tremendous asset.

I would also say in the interest of the concern about climate change and sustainability, that our laboratories are LEED certified, meaning we built them to the standards of a sustainable and responsible citizen so that they conserve water and electricity and have excellent staircases and so on and so forth. We are very fortunate to have made progress.

It is very difficult now, candidly, because the campus looks so good that people think they are done. Unfortunately, we still have people working in some labs that are not ready. They are still not modernized.

We have a number of people scattered all over the City of Atlanta, not to mention some real old facilities that NIOSH is occupying in Cincinnati and Pittsburgh as well. So I am not trying to focus entirely on buildings and facilities, but I can't recruit the best talent if I can't put them in safe and modern laboratories just like Dr. Zerhouni has those similar concerns.

We are very grateful for the progress. It is just so exciting, but it is also challenging to try to communicate that we need to get the job finished and we are not quite there yet.

I will say one of the challenges that has occurred is that new buildings may be efficient and effective, but they are not necessarily inexpensive to run and operate. Now that we own more buildings, we have to be sure to be able to keep up their maintenance so that we don't end up where we started with buildings that are poorly maintained and in need of more expensive repairs. We do have some unmet needs in terms of maintenance and repair.

EMERGENCY PREPAREDNESS

Mr. REGULA. Infectious diseases of animals and plants are one of the leading causes of economic loss to producers in the U.S. and Ohio. In the U.S., animal and plant diseases annually cost producers \$17,500,000,000 and \$30,000,000,000 respectively, and we have similar losses in Ohio.

The NIH has developed a model to construct regional BSL-3 laboratories throughout the United States to assist CDC and State health departments in the research and management of infectious disease outbreaks in the human population. Unfortunately, a similar model for dealing with threats of infectious diseases to animals or plants is not yet developed on the national level.

In the event of a national crisis such as an avian flu pandemic, will current Federal laboratories have sufficient personnel and infrastructure to address the threat, and how are you working with USDA on these threats?

Dr. GERBERDING. We have been working very hard on pandemic preparedness, and laboratory capability is obviously an issue domestically and a much bigger issue internationally. In the United States, our preparedness plan, which we are exercising too, allows us to scale and get the kind of throughput we need in the early phases of a pandemic.

Once a pandemic has arrived, you don't need to necessarily test every patient because you can assume that they have the pandemic strain. So early on at the beginning is the time when you need the rapidly accessible diagnostics. We believe our laboratory response network has made extraordinary progress and is up to that challenge.

But what we don't have is a point of care rapid test so that if you come into the emergency room, we can tell right away if it is the pandemic strain. We can tell you have flu, but we can't tell if it is the pandemic strain at that level of specificity. So there is work going on in the industry to try to develop better diagnostic tests.

In terms of our interaction with USDA, interactions can always improve, but we have an extraordinarily good intersection. We actually have one of the senior USDA scientists housed at CDC, who works in our emergency operations center when we are involved in any number of these animal-human disease outbreaks, like SARS or monkey pox or whatever.

We share scientific expertise in Atlanta through the University of Georgia. In Fort Collins, Colorado, we work side by side with Colorado State in their USDA facilities there. So we have tried to position our programs in locations where there is a natural connection.

Also, the head of our new National Center for Zoonotic Diseases is a former dean of the Michigan State University School of Veterinary Medicine, and he has created a huge network. We just had a whole bunch of veterinary students at CDC to get interested in public health veterinary medicine. So we are trying to build those bridges at every layer of the organization.

Mr. OBEY. Before I call on Ms. Lee, let me simply say that Mr. Walsh demonstrated one inconsistency in the Administration's budget request a minute ago.

I think Mr. Regula has demonstrated another one because you have talked to us about the needs for buildings and facilities. The Administration has zero budgeted that this year. Last year, they provided \$20,000,000. We provided \$55,000,000.

If I can tell one story, a very well-known American businessman from Atlanta came into my office a few months ago, asking me to please approve a large increase for CDC buildings. He was a fellow who had contributed \$125,000 to the President's campaign.

And so, I asked him. I said, why are you talking to me? Why aren't you talking to Karl Rove?

His response was I already talked to Karl, and Karl said, oh, don't worry about budgets. They are just a game.

So what we hear today is the result when these issues are treated as though it is just a game.

Ms. Lee.

HIV/AIDS PREVENTION PROGRAMS

Ms. LEE. Thank you very much, Mr. Chairman.

Good afternoon. I want to thank all of our panelists again for being here. I can't believe a year has passed.

I want to specifically ask Dr. Zerhouni and Dr. Gerberding a couple of questions with regard to the HIV-AIDS prevention programs that CDC funds based on the behavioral research that is conducted by NIH.

Recently, I think CDC released a report called Updated Compendium of Evidence-Based Interventions that are considered, I believe, the best interventions for HIV prevention programs.

Now my understanding, and you can clarify this for me, is that there were no abstinence programs, not a single one included in that list. If that is the case, I would like you to say something about that. If it is not the case, then I would like to find out what is in that.

Also, it included 49 evidence-based interventions, yet only 4 were newly identified for the MSM community who account for about 50 percent of the new infections. None of the interventions were primarily focused on black MSMs and none focused on Latino MSMs, which are two groups disproportionately affected by HIV and AIDS.

Let me just read something that the report says: "Some of the populations hardest hit by the HIV-AIDS epidemic or at greatest risk of infection or transmission were not represented. These populations include African American, Hispanic and other MSM of color, young MSM, particularly young African American and Hispanic MSM, substance-using MSM, transgender persons, HIV-positive intravenous drug users and rural populations."

So let me just ask you what accounts for the lack of approved interventions for the MSM community and what are you doing really to address this and also for transgender persons, HIV-positive IV drug users and rural populations?

Then, secondly, how are we ever going to address prevention in the United States if we don't have approved interventions based on the research for communities that are most impacted by this disease and how are your priorities established?

Then I just want to ask Dr. Gerberding about the testing, the HIV-AIDS testing that CDC has mounted in communities of color and how that is going and is it moving fast enough for us, given the rates of infection that we are unfortunately witnessing again.

Dr. ZERHOUNI. Well, thank you for the questions.

From the standpoint of the NIH, as you know, our budget for HIV-AIDS research is almost 10 percent of the NIH budget. About one-third of it is related to prevention, and we are completely aware of the greater risk of transmission in the populations that you have indicated.

I will have to go on the record and check our facts because I know that our strategy for HIV-AIDS research based on prevention, vaccine development and new therapies has a high focus and priority on the populations that you refer to.

The prevention issues for the programs that you mentioned are attached.

[The information follows:]

NIH BEHAVIORAL RESEARCH FOR HIV PREVENTION

The CDC developed the Updated Compendium of Evidence-Based Interventions with Evidence of Effectiveness. As NIH did not develop the Compendium, I am unable to address this question.

The NIH conducts and supports biomedical and behavioral research on all aspects of HIV prevention. The CDC considers the outcomes of studies in developing recommendations included in the Compendium. NIH supports a diverse portfolio of research studies to identify prevention strategies for a multiplicity of high-risk individuals, including men who have sex with men, transgender persons, women, substance users, and adolescents, persons from racial and ethnic populations, in geographically diverse settings. This research is challenging and must take into account complex social and cultural differences. As with any scientific study, rigorous research may not always yield desired outcomes.

NIH, through the Office of AIDS Research (OAR), develops an annual trans-NIH strategic plan for all HIV/AIDS research activities that establishes scientific priorities. The *Trans-NIH Plan for HIV-Related Research* is developed through a unique, comprehensive, rigorous, and collaborative process involving representatives from NIH ICs and other federal agencies, including the Centers for Disease Control and Prevention, the Veterans Administration, United States Agency for International Development, Department of Defense, and SAMSHA; non-government experts from academia, foundations, industry; and community representatives. The Office of AIDS Research Advisory Council, which provides ongoing advice and guidance on NIH AIDS research, also includes a senior CDC staff member as an ex-officio member.

The NIH planning process has identified HIV prevention research as the highest priority for AIDS research. In addition to behavioral strategies, NIH supports a comprehensive portfolio of prevention research, including basic and clinical research of vaccines and microbicides, prevention of mother-to-child transmission, pre- and post-exposure prophylaxis, circumcision, and other interventions. These prevention studies target specific at-risk populations on an individual, small group, and community level. For example, NIH supports a comprehensive portfolio to develop interventions for drug and other substance users. NIH research established that drug abuse treatment can reduce HIV transmission behaviors. Current research includes an NIH-supported research project to examine the barriers that African-American and Hispanic intravenous drug using couples encounter in securing HIV risk reduction interventions and drug abuse treatment. A number of NIH projects are elucidating risk factors for transgender

individuals to inform the development of specific interventions for this group. NIH also supports studies targeting rural areas of the U.S. For example, an NIH study is testing a telephone peer-counseling intervention for HIV-infected women in rural southeastern U.S. Additional studies are investigating targeted group interventions for rural African-American cocaine users as well as a study focused on rural Latino MSMs in the southeast U.S.

Dr. ZERHOUNI. But our commitment is in line with our colleagues at CDC and is where the research on effective prevention measures adapted to the appropriate environment of the individual needs to be focused.

Ms. LEE. Please do because I don't believe this report took into consideration those populations that I mentioned.

Dr. ZERHOUNI. Right. I am a little surprised at that because, frankly, I know for a fact.

Ms. LEE. Also, the abstinence-only programs in this report, I didn't find any that were identified as best prevention interventions.

Dr. ZERHOUNI. I am sure that Dr. Gerberding has more knowledge of that, but I will check into that and let you know about it.

Ms. LEE. Thank you.

Dr. GERBERDING. With respect to the testing program, for those who aren't familiar, we recognize that in America men who have sex with men and particularly African American men who have sex with men is the fastest growing population in terms of HIV infection. Sadly, the epidemic is going in the wrong direction in that population as I know you know.

I do want to say that among injection drug users, among children and among women, we have lowering incidence rates. So we are seeing progress in some populations, but this one truly stands out as an area that needs urgent attention.

A year ago, we convened the national opinion leaders from a variety of sectors including basketball and sports and everything, entertainment and faith-based groups to try to create a coalition of community advocates around awareness that this is a problem in the African American community and advocacy for people to reach out and get tested and kind of de-stigmatize the problem.

So we estimate in the last year we were testing about a million people and that we were detecting somewhere between twelve and twenty thousand infections that otherwise would have gone missed.

Now, testing is very helpful to the individual in terms of treatment, but testing is also an important intervention for prevention because we know when people know they are infected, they are less likely to infect somebody else. So this testing is part people need care but also part people need awareness so that they protect others.

I think this is our first year, and I can't really say the return on the investment at this point, but I am really optimistic that if we can continue and hopefully scale this, we will see a difference.

That goes part and parcel with our routine testing program now which is finally 27 years into the epidemic, getting an HIV test is a routine part of medical care if you come into the health system in more and more States. It is not true in every state yet because some still haven't finalized their regulatory changes needed to make that happen, but it is now a routine practice for people who are in the age group of people at risk to get an HIV test or opt out of it.

It does not require the elaborate, in some cases, time-consuming and somewhat invasive informed consent process that was a barrier to getting tested in these settings before.

Mr. OBEY. Mr. Lewis.

NIH PRIORITY PROCESS

Mr. LEWIS. Thank you very much, Mr. Chairman.

I am tempted to immediately pursue the discussion that Ms. Lee is raising regarding HIV. But before going to that let me mention it was, for a short time, my privilege to chair this Committee as Mr. Obey has that privilege presently. Until I had that job, I never had a chance to come to this Subcommittee for I had never served on it.

It is one of the most magnificent areas to work around here that I have experienced in public affairs, no small part because of that which NIH is about and those people who serve with you, Dr. Zerhouni. It really is a privilege to be associated with people who are doing the work that you are doing.

My Chairman wrung his hands a while ago about the fact that there is not enough money to go around and probably if you really want to deal with the whole world, there never will be. For example, when we were talking about the CDC building last year in conference because we had other priorities, it was the House who pushed back against the Senate's desire to increase the building and facilities fund as I recall.

Setting that aside, Dr. Zerhouni, you and I have talked a lot about my concern that there is not enough money to go around and thereby a need to rethink the way we spend money and readjust priorities from time to time, rather than just responding in responding to somebody who got a flow of funding last year and assuming that person ought to be the first one in line next year.

You have done a lot regarding those concerns with the common fund and the roadmap initiatives, but still the process whereby money flows to individuals or grants has not significantly changed. So I would like to have an update on where you think we are going in connection with that.

Dr. ZERHOUNI. This is an excellent question in terms of understanding the systems of research and what we do when the priorities, as we just heard from our sister agencies, change.

How does the NIH adapt to that? It cannot adapt overnight to a new paradigm. It has to move in a rational way towards the opportunities. In fact, we have over the past four years.

I can show you the areas of NIH funding that have had to decrease because of the priority setting process. For example, clinical trials, we have reduced our commitment to clinical trials by almost \$500,000,000. Why? Because we believe that you need to also focus on what we call translational research.

We have also launched a program called the Clinical and Translational Science Initiative because we have found that scientists who come up with great ideas and the ability of the industry to develop new therapies, but in the middle, there is a need to prove that what is discovered in a lab is going to work in the human population.

We have rearranged our portfolio. If you look at our portfolio, we still favor fundamental research because it is the route to fundamental progress.

But at the same time, I think, as you mentioned, the Roadmap, the Common Fund. If you look at a number of trans-institute ini-

tatives today, there is the blueprint for neuroscience research which really relates to both mental health as well as behavioral research. The diabetes programs are now integrated across their dimensions in terms of heart disease impact as well as other consequences of diabetes.

I think we have made progress, and I would like to thank Congress for reauthorizing the NIH through the NIH Reform Act of 2006, which I think is going in the direction of what you and I talked about: How do you better coordinate both within this Agency as well as within our agencies within HHS?

Mr. LEWIS. Thank you. I just wanted to make sure you didn't think I had forgotten about my interest in that.

But back to my colleague from Northern California, Ms. Lee, it was 1972 or 1973—in the VA–HUD Subcommittee where Lou Stokes and I worked so closely together, that I was involved in providing the very first funding for research in an arena known as AIDS at a time when almost nobody knew what it was about.

If we work together in a fashion that suggests that none of these major issues have anything to do with partisan politics but rather solving human problems, I think we can make real progress.

I must say that you will be intrigued, Dr. Gerberding, with the fact that a couple of years ago I had a visit in the Capitol from a guy by the name of Bono, and Dr. Gerberding and I had recently talked about problems in Africa.

Bono was going to see the President the next day, and his reason was to go and talk about HIV and AIDS in Africa. I suggested as he had the conversation, that HIV/AIDS was the highest priority, but there was another challenge we might do something about in the village called malaria.

A day and a half later, Bono is meeting with the President. He had two things to talk to him about, and both were impacted because of our addressing real human problems, recognizing that dollars can make a difference, but they really make a difference if we work together rather than fight with each other.

So thank you for that, Mr. Chairman.

Mr. OBEY. Thank you.

Let me simply say with respect to CDC buildings, last year, the President asked for \$20 million.

Mr. LEWIS. I didn't want to sidetrack.

BUILDING AND FACILITIES

Mr. OBEY. We gave him \$147 million bucks in the bill that he vetoed.

We then came back after that veto and provided \$55 million which, as I figure, is almost triple what the Administration requested. We did that even though the President insisted that we not have a dime above his requested level in the overall appropriations bill.

So I would say given the Administration's resistance, we did pretty well by CDC buildings last year.

Dr. GERBERDING. May I just say that I think Congress has really been very supportive of CDC's buildings and facilities for the five years that we have been building them, and we know that. We also started in a pretty dreadful place. So it is important to remember

that when you are out of the Beltway, sometimes you are out of sight and out of mind, and we kind of had a lot of catching up to do.

Mr. LEWIS. The desperate condition took place over maybe 20 or more years. Presidents come and go, and parties come and go. Human problems are constant.

Mr. OBEY. And sometimes those problems are magnified by what humans do.

Okay, is Mr. Udall here or did he leave?

All right, Ms. McCollum.

Ms. MCCOLLUM. Thank you.

I will kind of build on the conversation here, Dr. Zerhouni. You talked about efforts, research versus the increase in healthcare costs, and how that is a tension, that it is a race that we are in.

I believe that health research is our best hope for not only decreasing costs but for improving the quality of people's lives. So it troubles me when I see the budget and I see things flat funded, especially with what we know of what is going on currently with even the fuel prices to heat the buildings you are in. There is inflation.

And so, if you don't start counting in for inflation and the funding we know could always be increased. There is more to work on than you have time to work on and than the Congress will be able to fund right now. But then you add the flat funding and what you really have is a cut, in my opinion, a cut.

So I have had a lot of constituents in my office over the past several weeks and over the past several years, making the case for greater investment. Now, with flat funding and with what is going, what we are actually seeing is a cut in this budget.

I believe that you think we should be putting more into research. Do you have any idea? Did you have any conversations? As to when the Administration was making its proposals to you, what kind of dialogue takes place?

I would be curious in that because, Dr. Gerberding, in your testimony too, you talked about obesity and CDC plays a great role in keeping America healthy. I have been impressed by the Agency's attitude towards solving problems and doing things.

But I don't really see how we move forward on curing and prevention childhood obesity when we have cuts to school health programs, where we have the children so much, to put it as a former teacher, as a captive audience to be working with and finding out what kind of interventions work.

We also know, from what happened with smoking, children go back home and reinforce the message back home with parents and grandparents and that as well.

When I see these kinds of cuts and flat funding, I really wonder how you are going to be able to achieve, one, the goals that the American people have asked you to achieve and, two, your own goals. If you don't have the funding to accomplish what you know you can accomplish in one year, how can you build on that to really make the goals and objectives come true for a healthy America?

If you would both kind of tell me the conversations that get put in place. I don't mean to be disrespectful. I am just trying to understand this because there is going to be a new Administration, whether it is Democratic or Republican the next time around.

Enlighten me. What are some of the conversations that you have with the Administration when you put together these budgets?

Dr. ZERHOUNI. Well, the Chairman referred to my musical instrument playing, there are days where I would rather play that instrument than engage in that forceful dialogue, I can tell you.

Clearly, I think these are very difficult times. In my whole career, I have never had to manage a stretch of very, very difficult priority-setting, in a sense that would maximize the dollars that we have. Obviously, we could do more with more.

But I think it is important to realize that the most important dialogue that we can have is to stress the fact that historically, we are at the flexion point whereby the costs are going, as you heard, at 6 or 7 percent by my colleague, Terry Cline, and yet GDP, the gross domestic product, is not growing at the same rate.

Something has to be done. I don't believe that you can do it without a systemic view that includes educational issues. I don't believe we can change health behaviors without an intervention very early in the school years. We have shown this over and over again.

The dialogue is very forceful. Obviously, I believe that these times require you to make priority decisions and priority calls. At the end of the day we are also in need, in my view, to truly address the challenges in front of us. That will require a transformation, a transformation through discovery of the entire concept that we have currently of healthcare in this country.

Dr. GERBERDING. I would stipulate at the table are all agency heads, and there is probably not an agency head at HHS or across the government that couldn't think of really good things to do with resources if we had them.

We think if you invest in CDC, you get results. People care about those results, and we sure care about them. But we also know that the time and environment that we are operating in is a very challenging time from a budget perspective, and we can't have everything we wish we could have.

CDC has a unique situation, in a sense, because we have two major portfolios.

Mr. OBEY. Could I ask you a favor?

We have a problem. We have four votes coming. That is going to blow away the rest of this hearing, and I would like to give each member of the Subcommittee who hasn't talked at least a couple of minutes to ask questions. So could I ask you to respond further for the record and call on Dr. Weldon?

Dr. GERBERDING. Perfect.

Mr. OBEY. If you could limit yourself to about three minutes, then we all will get there in time to vote. Mrs. Lowey hasn't asked a question yet either.

MITOCHONDRIAL RESEARCH

Mr. WELDON. Mr. Chairman, I will make every attempt to be quick.

I want to thank all the witnesses, and certainly it is a pleasure to see you back here again. I thank you for all your hard work.

I just had a couple of quick questions, and it may be necessary to respond later.

We had the Secretary in last week. I mentioned to him about a case of a girl who the vaccine court had settled that her autism was caused by the injections and that she had an underlying defect in oxidated phosphorylation, a mitochondrial disorder.

I called one of the pediatric neurologists that was involved with the case, a fellow by the name of Zimmerman at Kennedy Kreeger. He was speculating that somewhere, maybe in the 10 to 20 percent of these autism cases, it may be possible that they have maybe not a mitochondrial disorder but mitochondrial dysfunction.

But he said something to me that was really interesting. He said, this is kind of an unusual hypothesis and it is out of the mainstream of what NIH is funding.

Dr. Zerhouni, are you aware of this at all? Has anybody brought it to your attention? Does CDC know about it, and is it something that we can get some investigative funds looking at if we get good grant proposals in?

Dr. ZERHOUNI. I would say a direct connection between a vaccine and a mitochondrial disease that affected the child to developing an autism spectrum disorder is a pretty unique set of events.

However, we just had a symposium in January about the issue of mitochondrial disease. There are over 40 conditions that can affect, in fact, metabolism in humans that could then tip them over, not just in the case of vaccination, but where the fundamental energy-generating organ now, called a mitochondrion, can play a role in many diseases.

We are looking at that in the context of diabetes, heart disease and obesity.

Yes, we knew that mitochondrial disease is an important topic. I was not aware of this particular connection, and we are looking into that.

Mr. WELDON. Yes, the vaccine court settled it, and one of the clinicians involved is investigating this, whether there may be some kind of a link. So I am glad what I hear you saying is it is an area of research you are pursuing.

My other quick question, I sent you a letter, Dr. Gerberding, on the MRSA issue. I don't know if you staff brought that to your attention.

I thought it was very interesting, very concerning. Particularly, obviously what caught my attention is I trained in that town and, as I recall, you had done as well. Certainly, I commend CDC for doing the research.

Were you going to be able to get back to me on the letter that I sent?

Dr. GERBERDING. [Remarks off microphone.] Obviously, I have been caught up.

Mr. WELDON. Right.

Dr. GERBERDING. [Remarks off microphone.] So I haven't responded to you directly, but yes, I saw your letter and read it myself. We have had a conversation about the appropriate response.

But I also am pleased to be able to tell you we are doing a lot of things about the MRSA problem. So I can update you on that when you have time.

Mr. WELDON. Yes, I figured you probably were.

Thank you, Mr. Chairman.

I thank the witnesses.

Mr. OBEY. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman.

I just want to make a quick statement. First, I would like to just kind of back up what my colleagues have said with regard to the budget. I mean we see this behavior all the time on the ground back in our districts, of what the need is, as you see it every day. This is clearly inadequate, and we all know that. To the extent that we can fix it, we are going to try to fix it.

I just would like to make one statement and, Dr. Cline, we have had conversations about this.

I feel like when we talk about a lot of these issues of public health, mental health, that it gets back, especially a lot of the stuff we watch on TV. It gets back to how American citizens deal with the level of stress that they have to deal with every single day and how that affects their behavior, how they deal with each other as kids in a classroom, how they react by grabbing a gun and ending up killing people. There is a variety of these issues.

I am just going to make a statement and submit some questions for the record, but I think if we want to get to the root of a lot of these issues: health, physical or mental.

I think we have to figure out how to teach our society and our citizens how to deal with the stress that they are put under every day, economic, how they pay for healthcare, what kind of job they are going to have, how their kids are going to go to college. These are all things that day after day after day affect their physical health and their mental health and if we don't figure out how to deal with a lot of those issues.

Some are policy, but some are habits that they can get into them, and we are going to need your help to do that.

I am going to yield the rest of my time to my friend, Mrs. Lowey.

ANTI-DEPRESSANTS

Mrs. LOWEY. Thank you very much to my colleague. Actually, it is a great segue to my question which I will express very briefly.

I don't know. You probably didn't see the New York Journal News on February 27, 2008, but you probably read about the New England Journal of Medicine study which was cited in that article. This is really for Dr. Cline and Dr. Gerberding, if you could respond. I don't know if we will have time today.

It was questioning the effectiveness in widespread prescription of anti-depressants, particularly to women and children. Parents in my district say many students in their children's school have been prescribed anti-depressants for behavior problems, that everyone is ADD.

It is on record that there is supposed to be a 40 percent increase in bipolar—I don't know if you call it a disease—and bipolar children. However, according to the psychiatrists I have spoken to in the district, this is impossible.

So I am very concerned about that. Are you familiar with the New England Journal and Medicine cited in this article?

Can you comment on research related to the over-prescription of anti-depressants and other drugs to children? And, you probably have about two minutes to address this issue.

So the bottom line is in talking to parents, PTA meetings that I attend, the use of anti-depressants among kids is so widespread. Give them Zoloft. Give them this. Give them Prozac. Could you comment?

Dr. CLINE. Certainly, and we would be happy to send you some information based on the data that we have accessible. I don't know. Dr. Clancy, I am sure you have some as well.

One of the things we know very, very clearly is that antidepressants prescribed appropriately and for the appropriate diagnosis can be very, very effective. It can indeed be lifesaving for individuals.

Part of the concern that we see at times is when something like that comes out is that then we see kind of a backlash, and we see under-prescribing that can take place as a result. There has been some concern about spikes in suicide as a result of the pendulum swinging so far the other direction.

So it is a complicated issue, and I want to make sure that we have enough information that is provided to you that is more comprehensive. It is a very complicated issue. I appreciate the question very much.

[The information follows:]

Mrs. Lowey: Can you comment on research related to the over-prescription of antidepressants and other drugs to children?

Dr. Cline: Certainly, and we would be happy to send you some information based on the data that we have accessible. (See attachment)

ANTI-DEPRESSANTS

SAMHSA appreciates the opportunity to comment on recent articles regarding rates of prescription of anti-depressants, particularly rates of prescription to women and children, and whether growth in the rates at which anti-depressants are prescribed should be a source of concern.

It should be noted that the Food and Drug Administration, the Centers for Disease Control and Prevention, the National Institutes of Health, and the Agency for Healthcare Research and Quality all have key Federal responsibilities in this area and can most authoritatively comment on the appropriate uses of specific medications, off-label use of medications, and trends in drug usage.

According to noted experts in child and adolescent mental health, standards for medication management for children are a challenging issue for the field because relatively few randomized controlled studies have been conducted. As a result, medication choices are frequently based on the experience of the individual practitioner or on standards of care for adults. At the same time, prescription medications are considered to be an important tool for many families and practitioners.

Within the Substance Abuse and Mental Health Services Administration, our mental health service programs are designed to promote evidence-based practices that may include a combination of clinical therapy and supportive community services. In clinical practice, it is common for medication treatments to be combined with psychosocial strategies.

A key principle for SAMHSA is to ensure family-driven care in which families are active and informed consumers of services. Because the family plays a major role in the social and emotional development of children, family-focused interventions have long been a part of child and adolescent mental health treatment and it is critical that families play an active role in reviewing the potential benefits and side effects of medications in close partnership with mental health service providers.

Mrs. LOWEY. I would appreciate that information.

I would also like to know, Dr. Cline, what kind of information is shared with parents, principals, teachers and the correct advice that they perhaps could give to parents. Maybe go see the doctor, don't ask me. But I would appreciate that.

Thank you very much.

Dr. CLANCY. If I could just add, this is an area where we plan to be making some investments in comparative effectiveness research, particularly focused around ADHD, so that parents understand what are the benefits and harms of treatment and that they can get this information in language and ways that they can understand.

Mrs. LOWEY. Are you aware of the New England Journal of Medicine study?

Dr. CLANCY. Yes.

[The information follows:]

Mrs. LOWEY. I would like to know what kind of information is shared with parents, principals, teachers and the correct advice that they perhaps could give to parents. Are you aware of the New England Journal of Medicine study? Could you just make a quick comment on that?

Dr. CLANCY. Yes, I think it would be easier if I did it for the record so that I have a chance to review it. I have read the abstract but not the full study. (See attachment)

CLINICAL TRIALS

This study highlights the impact of publication bias, where studies with positive findings are more likely to get published in peer reviewed medical journals than those with negative findings. Registering clinical trials with ClinicalTrials.gov helps to identify studies that are on-going or completed and allow researchers to learn which study findings have not been published. Clinicians and patients depend on syntheses of existing literature to guide diagnostic and treatment decisions, so minimizing the number of studies that remain unpublished is incredibly important.

AHRQ's Effective Health Care program examines the effectiveness and comparative effectiveness of diagnostic and therapeutic interventions for high priority areas, and relies on syntheses of existing studies and other sources of information. A high priority for our work is minimizing bias, emphasizing the importance of transparency in all phases of our work, and a strong focus on improving methods of synthesizing and documenting research to provide the most accurate scientific information possible. We approach the manufacturers of drugs and devices that are the subject of our comparative effectiveness reviews to submit any study findings that are not represented in the published literature to ensure we have the true denominator of studies available.

In regard to the effectiveness of antidepressants, AHRQ has published a comparative effectiveness review that includes a translation for clinicians caring for patients with depression and for patients who suffer from depression. The guide for clinicians can be found at: <http://effectivehealthcare.ahrq.gov/healthInfo.cfm?infotype=sg&DocID=9&ProcessID=7> and the guide for patients can be found at: <http://effectivehealthcare.ahrq.gov/healthInfo.cfm?infotype=sg&DocID=10&ProcessID=7> To research many different groups of patients, the patient guide is available on the Web, in print, in audio versions, and soon in Spanish.

Mrs. LOWEY. Thank you very much.

Mr. OBEY. Thank you.

Let me simply say if you can serve in this institution and not require antidepressants, it is a miracle. [Laughter.]

Mr. WALSH. Mr. Chairman, you are going to have to speak for yourself on that. Oh, I did just announce I am retiring. [Laughter.]

Mr. OBEY. Well, that was your first mistake and our loss.

Let me simply thank all the witnesses today. We appreciate your service and your being here.

The Committee will resume at 10:00 tomorrow with the Secretary of Labor.

BUDGET CUTS

Ms. DeLauro: Since the end of the doubling of the NIH budget in 2003, appropriations for the NIH have failed to keep pace with medical research inflation. Since 2003, flat funding has NIH reduced purchasing power by 11 percent. The FY 2009 budget request for NIH widens that gap to 14%. Please tell this Committee what impact funding levels that fail to keep pace with biomedical research inflation have had on your institutes and centers.

Dr. Zerhouni: The biomedical research and development price index, developed by the Commerce Department's Bureau of Economic Analysis, estimates a 3.5% inflation factor for FY 2009. In agencies and departments across the federal government, including NIH and HHS, there are competing demands that require strategic decisions to set and balance priorities within available resources.

The NIH budget request for FY 2009 is nearly \$30 billion and reflects NIH's priorities for biomedical research, including increases in the Common Fund, a 1% increase in stipends for pre- and post-doctorate fellows, and continued focus on early stage investigators. The FY 2009 request continues to fund competitively awarded research project grants, the mainstay of NIH supported research. In fact, the President's Budget request expects to support over 9,700 competing Research Project Grants, similar to the FY 2008 planned level.

Between 1998 and 2003, NIH supported an expanded biomedical research framework. The pace of discovery in biomedical sciences has never been as rapid or as promising as it is now. Research institutions throughout the country have leveraged federal funds and invested their own resources in research facilities and science faculty.

NIH continues to think creatively and strategically to sustain the successful research programs of our talented grantees and intramural scientists and to capitalize on the opportunities and intellectual resources that the American public has already invested in the NIH. NIH faces many tough choices and we continue to make the difficult calls necessary to sustain the vitality of our science in an increasingly competitive global environment.

Some of the ways in which NIH has managed current resources across the Institutes and Centers include: adjusting support for clinical trials at NINDS, NICHD, NEI, NIDCD, NIMH, and NIAAA; scaling back certain research training programs at NIDDK, NIAMS, NCRR, FIC, and NLM; data and tissue repositories supported by NCI, NINDS, NIMH, and NHGRI have not been expanded as initially planned; and NIDDK, NIDCD, NHGRI, and NIBIB slowed their planning for developing specific computer interface, non-invasive monitoring, and advanced imaging and delivery technologies.

While inflation may reduce overall purchasing power for the bio-medical research community over the long haul, the FY 2009 request will continue to move science forward. We will continue to invest in the best science and work with the community to

use the resources provided to develop and translate scientific advances into therapies, cures, and diagnostics.

CDC'S DIVISION FOR HEART DISEASE AND STROKE

Ms. DeLauro: As a member of the Congressional Heart and Stroke Coalition, I am concerned that the President proposes to cut the budget for CDC's Division for Heart Disease and Stroke by nearly \$1.23 million. This is particularly disturbing in light of the recent CDC survey that shows only 1 in 4 respondents knew the warning signs of a heart attack and to call 9-1-1. The lead author of the study called this "alarmingly low." I understand that this is a decline from the survey in 2001 that showed 1 in 3 knew that information. Dr. Gerberding this is not the time to cut funding for heart disease and stroke prevention. Heart disease, stroke and other cardiovascular diseases remain the No. 1 killer in every state and remain largely preventable, so each state should receive basic implementation funding for CDC's State Heart Disease and Stroke Prevention Program, but currently only 13 states receive these resources. Please explain the rationale of this proposed cut to the Committee.

Dr. Gerberding: CDC's State Heart Disease and Stroke Prevention Program works in states across the nation to increase control of high blood pressure and high blood cholesterol, improve knowledge of the signs and symptoms of heart attacks and stroke, increase awareness of the importance of calling 9-1-1, improve emergency response and the quality of care for heart disease and stroke, and reduce cardiovascular disparities. Since 1998, the CDC has funded more and more states to implement heart disease and stroke prevention programs. Currently, 33 states and the District of Columbia receive funding including:

- 13 states that receive resources for basic implementation of heart disease and stroke prevention programs; and,
- 20 states and the District of Columbia to build capacity for their heart disease and stroke prevention programs.

CDC anticipates that additional states will be supported with the increase in the Fiscal Year 2008 appropriation.

The Fiscal Year 2009 President's Budget maintains an increase of over \$5 million over the FY 2007 base for Heart Disease and Stroke. This funding level will permit CDC to maintain support for the states funded in Fiscal Year 2008.

WISEWOMAN

Ms. DeLauro: I have long championed CDC's WISEWOMAN program—Well-Integrated Screening and Evaluation for Women Across the Nation—that screens uninsured, under-insured and low-income women ages 40 to 64 for heart disease and stroke risk and provides those with abnormal results with counseling, education, referral and follow-up. I am pleased that since January 2000, this program has screened more

than 70,000 women and has provided more than 170,000 lifestyle intervention sessions, and I want to thank you for your support of the program. Yet, an alarming 3 out of 4 of these women were found to have at least one risk factor for heart disease and stroke—their No. 1 and No. 3 killers respectively. I understand that the FY 2008 appropriations will allow CDC to support an additional 6 states, bringing the program, which is now in the midst of a national competition, into 20 states. In your professional judgment, how much would it cost to provide all states with a WISEWOMAN program?

Dr. Gerberding: The WISEWOMAN program, which helps women with little or no insurance gain access to important screening and lifestyle interventions, is an integral part of the nation's efforts to reduce heart disease and stroke among the most vulnerable Americans. These services are made available to participants of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The women enrolled in WISEWOMAN from 1995 through 2005 were at high risk for heart disease and stroke—74 percent were overweight or obese, 27 percent smoked, 24 percent had high blood pressure, and 22 percent had high cholesterol. As of 2007, there were 15 funded WISEWOMAN programs in 14 states. In the Fiscal Year 2008, the Appropriation bill included language that directed the program to provide grants to not fewer than 15 states, tribes or tribal organizations. The CDC is currently in the process of a new WISEWOMAN funding opportunity announcement and anticipates making awards later this year to more than 15 states, tribes or tribal organizations.

In recent years, WISEWOMAN has served between 10,000-12,000 new women each year. However, approximately 500,000 women received breast and cervical cancer screenings and were eligible for the heart disease and stroke screenings as well.

In our professional judgment expanding WISEWOMAN to have a presence in all states, territories, and eligible Native American tribes, at the current level of funding per site, would cost approximately \$68 million per year. This estimate does not factor in other competing priorities and was developed without fiscal constraints.

PANDEMIC INFLUENZA

Ms. DeLauro: I have been tracking progress on our efforts to prepare for a pandemic influenza outbreak. One of the key parts of that plan is that in addition to federal stockpiles of key medicines and supplies, we also need states to act to establish their own stockpiles. For the stockpile of antivirals in particular, the national plan calls for enough to treat 25% of the population and to reach that goal, states have to act.

It is my understanding that to date, the federal government has purchased the 50 million courses of treatment as recommended under the NSPI, while the states have stockpiled only approximately 19 million of the 31 million courses of antivirals called for in the NSPI.

Some states have completed their stockpiles, some states are partially done and others have yet to act. My own state of Connecticut hasn't moved forward with any purchases of antivirals yet.

- Isn't this evidence that we do not have buy in from all the states?
- At a time when we are passing \$150 billion economic stimulus packages – with state budgets feeling the pinch - is it smart public health policy to base the completion of our influenza preparedness efforts on state purchases that may never be forthcoming?
- What can we do to make sure all states act?
- If even a couple of states refuse to act in advance of a pandemic, the U.S. will never reach its national goal of stockpiling enough antivirals for 25 percent of the population. How do you plan to address the shortfall?

Dr. Gerberding: The national pandemic influenza antiviral drug stockpiling goal is 81 million treatment courses with 6 million designated for early containment usage at pandemic onset and 75 million treatment courses for treatment of infected persons. As of Feb. 22, 2008, forty-five States, territories, and the District of Columbia have procured 21.7 million treatment courses of influenza antiviral drugs. Only six States do not intend to use their Federal subsidy allocation. The present deadline for States to utilize their Federal subsidies to purchase antivirals for pandemic stockpiles is July 31, 2008. By the end of March 2008, HHS will complete communications with those States that have not fully utilized their Federal subsidy allocations to ascertain the status of their commitments to complete this pandemic preparedness measure. Subsequently HHS will appraise the State antiviral drug stockpile program and determine the next steps including reapportionment of Federal subsidies to States.

Major issues preventing some States from purchasing influenza antivirals were the expiration dating and shelf life extension of these products. Recently the FDA accepted the product claim by Roche for Tamiflu® to increase expiration dating from five to seven years; the new expiration dating would apply to both Federal and State pandemic stockpiles of this product. Coordination of the manufacturer, FDA, States, and third party companies is underway for the relabeling of the product already in State stockpiles. Lastly, the issue of being able to use the pandemic antiviral stockpiles in States for severe seasonal influenza outbreaks has been a limiting factor. New Mexico has solved this problem by purchasing the antiviral directly from the manufacturer at greater than the Federal contract price but considerably less than retail prices. Their stockpile has the added flexibility to address both seasonal and pandemic influenza outbreaks and for treatment and post-exposure prophylactic usage.

Currently HHS has obligated \$91 million of the \$170 million appropriated for Federal subsidies to State antiviral drug stockpiling (an additional \$27 million will be obligated later this month). HHS will obligate these funds over the next six months as

orders by States using the Federal antiviral drug contracts emerge. Decisions on remaining funds, if any, will be part of the next steps process described above.

The State of Connecticut, like other States at the onset of an influenza pandemic, will receive its *pro rata* allotment of influenza antiviral drugs from the Strategic National Stockpile. The Federal stockpiled antiviral drugs will comprise 59% of the total number of antiviral drug treatment courses recommended for each State; the remaining 41% is the responsibility of each State, for which 23 States have completed to date. Connecticut and other States that have not completed their State stockpiling of antiviral drugs, have until July 31, 2008 to utilize their full allotment of Federal subsidies and Federal contracts with antiviral drug manufacturers to procure these drugs at significant savings. Afterwards, States may continue to purchase these antiviral drugs for their pandemic antiviral drug stockpiles using their own contracts with the manufacturers.

Secretary Leavitt has stated on numerous occasions that pandemic preparedness is a shared responsibility, that the Federal government cannot shoulder the entire burden, and that States, local government, businesses and families must first rely on themselves to become fully prepared.

NATIONAL CHILD TRAUMATIC STRESS INITIATIVE (NCTSI)

Ms. DeLauro: I am concerned about the approximately 50 percent proposed cut to the National Child Traumatic Stress Initiative. As you know, each year more than one million children are abused or neglected in their home, and three million children witness domestic violence. In addition, 600,000 children are victims of violent crime, 20,000 wounded by gunfire, and a growing number are injured or killed at school. We know the effects of psychological trauma associated with this violence affect these children for years to come, often setting them on a path of hardship at every level. As authorized under the Children's Health Act of 2000, NCTSI is a modest but critical investment in treating children who witness serious violence. Why would the president propose to cut this vital program? Shouldn't we be expanding initiatives such as this, instead of cutting back?

Dr. Cline: The National Child Traumatic Stress Initiative continues to be a valued component of SAMHSA's program efforts for children. SAMHSA maintains its existing commitments to child trauma grant projects in the FY 2009 budget. While a significant number of grants complete their activities in FY 2008, continuation grants and contracts for this program are supported in FY 2009. In addition, SAMHSA supports the mental health needs of children through the Youth Violence Prevention program and a proposed increase of \$12 million for the Children's Mental Health Services program.

HEALTH DISPARITIES

Mr. Jackson: Dr. Zerhouni, during the last several years, Congress has directed more funding to your office for the NIH Roadmap and other cross-cutting initiatives. How have those funds been utilized to address health disparities—an area of priority identified by you during last year’s hearing?

Dr. Zerhouni: Health Disparities was highlighted via the Common Fund planning process that occurred over several months in 2006 and 2007 as an area that needed further conceptual development. The goal of all Common Fund programs is to transform the way research is conducted in a given area of science by addressing seemingly insurmountable barriers that prevent progress in that area. The question within Health Disparities is, therefore, “What are these barriers – why is the field of Health Disparities Research not advancing as quickly as we would like?” The complexities of Health Disparities Research make this a difficult question. There are many barriers, and many are being addressed by existing programs funded through the NCMHD and the other Institutes and Centers. Similarly, existing Common Fund programs, although not specifically focused on Health Disparities, address issues that are important for minority health.

One example is the Interdisciplinary Research Program, which includes a project focused on developing tools to measure psychosocial stress that contributes to health disparities. A second project within this program focuses on development of data collection methods that link social and behavioral factors with biological issues that underlie health disparities. A new Common Fund Program to be launched this year – the Human Microbiome Project – is also expected to be highly relevant to Health Disparities. These programs illustrate how different Common Fund programs, while not specifically targeted to Health Disparities, may contribute to significant issues in this area.

Although multiple Common Fund programs are addressing issues of importance to Health Disparities, a trans-NIH Working Group has been formed to consider whether there is an overarching grand challenge specifically in Health Disparities research that meets the criteria for funding via the Common Fund. This group is considering several options and is expected to put forward a proposal in the Common Fund planning process that will occur this year.

Mr. Jackson: Dr. Zerhouni, at last year’s hearings, we asked about the status of the second NIH strategic plan on health disparities. It still had not yet been cleared. Has that plan been cleared? If it has, how can I get a copy? If it has not, what is the reason for the delay? What effect is the delay in clearing the strategic plan on health disparities having on the NCMHD and the Institutes and Centers at NIH in achieving their health disparities goals.

Dr. Zerhouni: "NIH is working to address concerns that have been identified with the plan and related issues. The plan will be available on the NCMHD website <www.ncmhd.nih.gov> when it has been cleared. When the plan is finalized, the NIH Institutes and Centers can begin to plan collectively for the next five year plan."

Mr. Jackson: Dr. Zerhouni, Dr. Tom Insel, the director of the National Institute of Mental Health at NIH, is planning to eliminate funding for his institute's minority training program. As you know quite well, new and young investigators continue an uphill climb in terms of breaking into the NIH grant pool for the first time. In fact, your testimony from March 2007 states that it is "critical that NIH...continue to work hard to encourage diversity among its scientists across all strata of our society." Why is NIH's Mental Health Institute planning to abandon its established program that helps underrepresented minority professionals achieve positions of leadership in academia and research around the country and has increased the number of minority investigators successfully competing for NIH research grants?

Dr. Zerhouni: Training the next generation of investigators, including those from a diversity of backgrounds, such as new minority investigators, continues to be a high priority for NIMH. Over the next few years, however, NIMH is strategically decreasing the percentage of its budget invested in all training programs. For example, NIMH spent approximately 10.4 percent (\$125,299,000) of its budget on overall training in FY2004 and approximately 8.9 percent (\$109,545,000) in FY2007. The goal is to reach 8.6 percent in the next several years, reaching a level still significantly higher than the NIH average of 5.3 percent of an Institute's budget. NIMH determined that this reduction was necessary in order to strike a strategic balance between building the pipeline of potential new investigators through research training and maintaining a viable pay line that will allow newly independent researchers to successfully compete for research project grants.

NIMH currently supports a number of programs specifically designed to increase the diversity of the mental health research workforce. NIMH continues to promote diversity through the Ruth L. Kirschstein National Research Service Awards for Individual Predoctoral Fellowships (F31) to Promote Diversity in Health-Related Research and the Mental Health Dissertation Research Grants to Increase Diversity (R36). These programs focus on training individuals, under the guidance of established NIMH investigators, in research that addresses the priorities of the Institute. These programs support research conducted by students, including those from populations that are underrepresented in biomedical and behavioral science; students with disabilities; and students from socially, culturally, economically, or educationally disadvantaged backgrounds that have inhibited their ability to pursue a career in health-related research.

The NIMH Career Opportunities in Research Education and Training Honors Undergraduate Research Training Program (T34) provides institutional support to strengthen research and research training experiences of undergraduate minority students and others in scientific disciplines related to mental health. NIMH also supports an institutional training program titled: Institutional Research Training Programs: Increasing Diversity (T32). The objective of the program is to support national or regional research training programs that will recruit, train, and retain pre- and/or postdoctoral trainees from

underrepresented groups to help ensure that a diverse pool of highly trained scientists is available to address the Nation's biomedical, behavioral, and clinical research needs in research areas relevant to NIMH. Finally, NIMH participates in the NIH Research Supplements to Promote Diversity in Health-Related Research program that provides funds through administrative supplements to existing grant awards to improve the diversity of the research workforce by supporting and recruiting students, postdoctorates, and eligible investigators from groups that have been shown to be underrepresented. These supplements can provide invaluable learning experiences for developing minority scientists by participating first-hand in cutting edge research.

In order to focus and enhance research training priorities, the National Advisory Mental Health Council (NAMHC) recently convened a workgroup on research training. This workgroup will advise the NAMHC on NIMH's investment in research training and will provide strategic recommendations about how NIMH could better achieve its goals of recruiting, training, and retaining a diverse workforce. The first meeting of the NAMHC workgroup on research training was held in February 2008, with subsequent meetings scheduled for March and May 2008.

COST SAVINGS AND HIV

Mr. Jackson: Is there any definitive scientific literature on the cost savings associated with early diagnosis of HIV compared to a late diagnosis? Would this be an appropriate study for AHRQ?

Dr. Clancy: No, there is no definitive evidence (yet) on the cost savings associated with early diagnosis of HIV compared to a late diagnosis.

Although early diagnosis of HIV disease is essential so that patients may receive appropriate and timely care, there is considerable evidence that a large segment of newly diagnosed HIV-infected individuals are being diagnosed late in the course of their infection. Studies show that between 30% and 45% of persons diagnosed with HIV are identified after their CD4+ T-cell count had slid below 200 cells/ μ L. For example, a rigorous study based on the review of nearly 500 medical records of patients diagnosed with HIV infection in Kaiser Permanente Medical Care Program and Group Health Cooperative Washington State found that 43% of patients identified with HIV disease had CD4+ T-cell counts <200 cells/ μ L at the time of diagnosis.¹ This finding is notable because it reveals that even persons who live in areas where most health care providers are familiar with the care and treatment of persons with HIV disease and who have good access to care that HIV infection is often not identified until the disease has progressed beyond the point where guidelines recommend that patients receive antiretroviral treatment.

¹ Klein D, Hurley LB, Merrill D, Quesenberry CP Jr. CHAIR review of medical encounters in the 5 years before a diagnosis of HIV-1 infection: implications for early detection. *J Acquir Immune Defic Syndr* 2003; 32: 143-152.

Even though there is no definitive evidence on the cost savings associated with early diagnosis there is evidence that early diagnosis of HIV (i.e., diagnosis before a person's CD4 T-cell count reaches 200 cells/ μ L) enables clinicians to initiate timely antiretroviral therapy that reduces the rate of decline in a patient's CD4+ T-cell count, and that this reduces the cost of treating newly diagnosed HIV patients. Mauskopf and colleagues explain (p. 562), "Two recent Monte Carlo simulation modeling studies comparing the cost-effectiveness of early versus later initiation of therapy estimated that early initiation of therapy (>200 cells/ μ L) is more cost-effective than late initiation (<200 cells/ μ L) because the person is held for a longer time in a disease stage that is less severe."² In addition, Krentz and colleagues found that the mean annual cost for the year following diagnosis of HIV patients in southern Alberta who were late presenters (i.e., persons whose infection was identified when their CD4+ T-cell counts <200 cells/ μ L) was 2.2 times the mean annual cost for the year following diagnosis of HIV patients who were early presenters.³

Nevertheless, there is no information in the literature about how the cost of care varies between early and late presenters after the year following diagnosis. While it might not be practical to devise a study to compare the lifetime cost of care of early and late presenters, it is certainly possible to devise a study that compares the cost of care of early and late presenters during the first 5 or even 10 years following detection.

Estimates of the survival of persons with HIV disease are now 20 years or more, and problems in disentangling the costs of various ailments encountered by HIV patients from the cost of treating HIV disease are amplified due to the lengthy expected survival times as is the probability that significant changes in the standard of care will occur over the patient's lifetime.⁴ These obstacles makes it impractical to estimate the lifetime cost of treating persons with HIV disease (note, analysts rarely estimate the lifetime cost of treating heart disease, diabetes, and many types of cancer for the same reasons). It should be noted that published studies reflect work done prior to recent efforts to promote widespread screening for HIV.

A study examining the relationship between early diagnosis and cost of care for 5 or 10 years following detection could possibly be conducted under the auspices of the HIV Research Network (HIVRN). The HIVRN is a network of HIV care providers supported by AHRQ and HRSA. The HIVRN was initiated in 2001 with a contract to Johns Hopkins University School of Medicine, and the project has successfully assembled a longitudinal database that can track clinical status and health services utilization for over 30,000 HIV-infected patients for multiple years. This linked data set represents a powerful source of information by which to examine the impact of recent changes in treatment regimens and to simulate the impact of future changes in the care of

2 Mauskopf J, Kitahata M, Kauf T, Richter A, Tolson "HIV antiretroviral treatment: Early Versus Later" *J Acquir Immune Defic Syndr*. 2005 Aug 15;39(5):562-9.

3 Krentz HB, Auld MC, Gill MJ "The high cost of medical care for patients who present late (CD4 <200 cells/ μ L) with HIV infection" *HIV Med* 2004 Mar;5(2):93-8.

4 Paltiel AD, Weinstein MC, Kimmel AD, et al. "Expanded Screening for HIV in the United States – An Analysis of Cost-Effectiveness" *The New England Journal of Medicine* 2005 Feb. 10; 352(6): 586-595.

HIV patients. HIVRN data could be utilized to compare the cost of treating patients who were identified early during the course of their disease to the cost of treating patients who were identified later in the course of their disease. AHRQ and HRSA would need to explore the full extent of conducting such a study to determine the capability.

CDC's RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

Mr. Jackson: Dr. Gerberding, the Racial and Ethnic Approaches to Community Health across the U.S. (REACH) is the cornerstone of CDC's efforts to eliminate racial and ethnic health disparities in the United States. Former Surgeon General David Satcher has publicly stated that the REACH program is one of the country's most successful programs at demonstrating a capacity for working within communities to reduce health disparities. One good example is the impact this program has had on reducing the number of diabetic related amputations across racial lines. Do you agree that this program has been successful in reducing health disparities, and do you agree that it is a program which should be expanded?

Dr. Gerberding: Yes, this program has been highly successful in reducing health disparities. REACH U.S. is demonstrating that health disparities can be reduced and the health status of groups traditionally most affected by health inequities can be improved. For example:

- The REACH Charleston and Georgetown Diabetes Coalition in South Carolina focuses on diabetes care and control for more than 12,000 African Americans with diabetes. As a result of the coalition's work, a 21 percent gap in annual blood sugar testing between African Americans and whites has been virtually eliminated. In addition, more African Americans in the target area are getting the recommended annual tests to monitor their cholesterol levels and kidney function and are being referred for eye exams and blood pressure checkups. Lower-extremity amputations among African Americans with diabetes also have decreased sharply. For example, in Charleston County, the percentage of amputations among African American males with diabetes who were hospitalized decreased by almost 54 percent over a 7 year time span. In Georgetown County, the rate of amputations for this same group decreased 54 percent over a 3 year time period.
- The Alabama REACH Breast and Cervical Cancer Coalition works to increase breast and cervical cancer screening rates for African American women throughout the state. In Choctaw County, African American women were much less likely to get a mammography screening compared to white women. In 8 years, the proportion of African Americans who received mammography screenings increased from 29 percent to 61 percent, and a previous black/white screening gap was eliminated. In Dallas County, a lower mammography screening rate among African American women (30 percent) compared to white women (50 percent) was virtually eliminated within the same time frame. According to data from the eight counties that the Alabama REACH program focuses on, the gap in mammography screening rates between African

American and white women decreased by 76 percent over the same 8-year time span.

- In Lawrence, Massachusetts, the REACH Latino Health Project, culturally-tailored interventions improved blood sugar and high blood pressure control and improved quality of care among Latinos with diabetes. Blood sugar measures improved by 8.7 percent, systolic blood pressure improved by 17.5 percent, and diastolic blood pressure improved by 14.4 percent. The percent of diabetic patients referred for eye exams improved by 26.5 percent, the percent whose smoking status was reviewed more than doubled, and those whose activity status was ascertained increased by 74.2 percent.

In addition, data from the REACH Risk Factor Survey indicated that across the REACH Communities:

- In 2001, the proportion of African Americans in REACH communities who were screened for cholesterol was below the national average. By 2004, this percentage exceeded the national level and it continued to increase through 2006.
- In 2002, Hispanics from REACH communities were less likely to be screened for high blood cholesterol levels than were those in the national Hispanic population. The gap was even wider when comparing Hispanics from REACH communities with the overall national population. By 2006, the cholesterol screening rate for Hispanics from REACH communities surpassed that for the national Hispanic population, and the gap between the rate for Hispanics from REACH communities and the overall national average was closing and continues to improve.
- The proportion of American Indians in REACH communities who are taking medication for high blood pressure increased from 67 percent in 2001 to 74 percent in 2004.
- Cigarette smoking among Asian men in REACH communities decreased from 34.7 percent in 2001 to 19 percent in 2006.

Communities across our nation could benefit from implementing the strategies of REACH. Lessons learned and successful models can be replicated by other communities. CDC will be working closely with the REACH Communities to document successful strategies and valuable lessons which can be disseminated widely. By sharing effective strategies and lessons learned from REACH communities, CDC can give more communities and public health programs across the country the tools needed to eliminate health disparities among minority populations.

Mr. Jackson: Dr. Gerberding, I am very pleased that the CDC has initiated the HIV Testing Initiative among African Americans. At this point, how is this program moving forward?

Dr. Gerberding: Launched in 2007, the President's Domestic HIV Testing Initiative seeks to improve the health of HIV-infected persons and decrease HIV incidence by increasing the proportion of persons who are aware of their HIV infection.

Through this initiative, CDC will test between 1 - 2 million persons per year, with the primary goal of increasing early HIV diagnosis in jurisdictions with a high burden of AIDS among disproportionately affected populations. HIV testing provides a critical pathway to prevention and treatment services to prolong the lives of those infected and help stop the spread of HIV in the hardest hit communities across the United States.

In late 2007, CDC awarded \$35 million to 23 jurisdictions representing 80-85 percent of the reported annual new cases of AIDS among African Americans. The project period of these grants is up to 3 years.

On January 31 - February 1, 2008, CDC held a grantee meeting in which all 23 of the funded jurisdictions were represented. The purpose of the meeting was to provide grantees with an overview of the announcement's programmatic information requirements and expectations; CDC's program monitoring role and responsibilities; and reporting and evaluation guidelines.

In 2008, CDC will continue to support these 23 jurisdictions. In 2008 and 2009, CDC will also support awards to states eligible for the Early Diagnosis Grant program. Funds for the Early Diagnosis Grant program will be used for testing and referral, partner counseling and referral services, perinatal HIV prevention, and HIV testing services in STD clinics and drug treatment centers.

Mr. Jackson: How many people have been tested, and what is the expectation for fiscal years 2008, 2009, and 2010?

Dr. Gerberding: CDC estimates that in 2007, over 1 million persons, mostly African Americans, were tested for HIV through the initiative. In May 2008, CDC will award funds for the Early Diagnosis Grant program; it is not clear how many states will be eligible for this funding. Outcomes related to the core activities of the President's domestic HIV initiative in FY 2008 will be determined after funds are awarded for the Early Diagnosis Grant program. In FY 2009, CDC estimates that about 1.5 million persons will be tested through the initiative. Estimates for FY 2010 are not yet available.

Mr. Jackson: Dr. Gerberding, we understand that this year's flu vaccine did not perform nearly as well as expected. We understand that new technologies are available that would be predictive of which influenza strains to include in the vaccine formulation. These technologies are centered around reliable, high-throughput in vitro methods for evaluating human immune response. Considering that thousands of Americans suffered from flu-like symptoms this year due to the ineffectiveness of the vaccine, the Committee would be interested in how the CDC is engaging with these technologies to prevent this from happening next year.

Dr. Gerberding: Early each year, potential vaccine strains are evaluated to determine those most likely to provide protection against anticipated circulating influenza viruses in the coming influenza season. The selected vaccine strains must demonstrate good capability to grow in eggs, since the vast majority of influenza vaccines

manufactured in the United States use eggs to make the viruses used in the vaccines. The manufacturing process for influenza vaccines requires sufficient time to identify H3N2 influenza viruses that grow well in eggs (H3N2 unfortunately is one influenza virus that does not grow as well as other influenza viruses in eggs) and to then grow the viruses in eggs. Therefore, vaccine strains must be chosen many months before the influenza season begins.

The delays in identifying suitable drifted H3N2 strains for updating the composition of the most common formulation of influenza vaccine, trivalent inactivated vaccine (TIV), are due to the difficulty of growing influenza viruses in chicken embryos. Chicken embryos are the only FDA-approved substrate for manufacturing TIV in the United States. Less than one percent of the clinical specimens inoculated into eggs yield a virus isolate; many of which do not have the desired properties.

CDC and other agencies in the Department of Health and Human Services maintain a continuous review of the multiple steps for selecting vaccine candidates and are evaluating various approaches to decrease the time for identifying candidates and for improving the selection of candidates with highest levels of protection. We are interested and engaged in evaluating new and experimental approaches to in vitro methods for evaluating human immune response. While some of these methods may show promise in elucidating immune responses more rapidly, predictive high throughput systems do not substitute for egg isolation of H3N2 viruses, which remains a requirement for vaccine strains and continues to be a critical control point that can delay vaccine manufacturing.

MINORITY FELLOWSHIP PROGRAM

Mr. Jackson: Dr. Cline, I am disturbed that your budget proposes to eliminate funding for the Minority Fellowship Program. Every year I request these funds be restored, and every year the administration proposes to eliminate them. You know this program's purpose is to increase the number of minorities who become mental health providers and I'm sure you know that studies show that minorities are more likely to seek treatment and follow-up from minority providers. One in 4 adults suffer from a mental disorder and only 7% get treatment. Moreover, minorities are less likely to receive treatment. What is the rationale for eliminating the Minority Fellowship Program?

Dr. Cline: The goal of the Minority Fellowship Program is to place practitioners in clinical settings; however, only 20 percent of nursing program participants end up working in clinical care settings, only 15 percent of psychiatry participants move on to a primary clinical work setting, and only 1 percent of social work participants move on to a clinical setting. The goals of this program are better addressed through HRSA programs. The FY 2009 President's Budget includes \$121 million for the recruitment and retention of clinicians through the National Health Service Corps, which places clinicians including behavioral health professionals in communities of greatest need such as underserved racial/ethnic minority communities.

INFANT MORTALITY AND RACIAL DISPARITIES

Ms. Roybal-Allard: The U.S. ranks 28th in international infant mortality rate comparisons, largely because of the racial and ethnic disparities that exist. Within the Chronic Disease Center there is a Racial and Ethnic Approaches to Community Health (REACH) program whose focus is specifically to find solutions to the racial and ethnic Health Disparities that exist in chronic diseases.

Is there a similar program within the National Center on Birth Defects and Developmental Disabilities (NCBDDD) to address disparities in infant mortality and birth defects?

Dr. Gerberding: Racial and ethnic health disparities are a key element in NCBDDD's priorities. While NCBDDD does not have a dedicated program similar to REACH, much of NCBDDD's efforts are focused on racial and ethnic disparities in infant mortality and birth defects. We know that certain birth defects occur more often in racial and ethnic minority groups and have worse outcomes when they occur in those groups. For instance, Hispanics continue to suffer from much higher rates of spina bifida than other racial and ethnic groups. Although flour fortification in 1998 has lowered rates significantly among all racial and ethnic groups, Hispanics still have higher rates of spina bifida. Working with several national and state partners, NCBDDD has developed education materials to address this health disparity (see <http://www.cdc.gov/ncbddd/folicacid/>). By developing and implementing evidence-based strategies, NCBDDD is helping increase awareness to help reduce the occurrence of spina bifida and anencephaly among Hispanics. Further, we are continuing to target prevention efforts to Hispanics by examining the potential for corn flour fortification, which is consumed more by this group.

NCBDDD also funds programs to prevent fetal alcohol spectrum disorders (FASDs) that target racial and ethnic minorities. FASDs are more common in American Indians/Alaskan Natives and African-Americans. A recent NCBDDD study tested an intervention to reduce alcohol-exposed pregnancies in high-risk women which shows great potential in diverse population groups. NCBDDD currently funds several FASD state-based programs to implement similar interventions that target minority women. For example, there is a project in South Dakota working with American Indian/Alaskan Native women and similarly, in Michigan, working with African-American women. NCBDDD, in partnership with the Indian Health Service, is in the planning stages to adapt these kinds of prevention interventions to specifically address the needs of American Indian/Alaskan Native women. NCBDDD works to educate medical and allied health students and health care providers through FASD regional training centers, one of which targets minority students and health care providers. Intervention and health education strategies hold great promise for healthier mothers and babies in these populations.

NCBDDD's studies confirm that racial and ethnic disparities exist in survival rates for children with certain birth defects, for example, Down syndrome, congenital heart defects, and spina bifida. A 2006 NCBDDD study on children with Down syndrome in the Atlanta area from 1979-1998 found that despite an overall increase in survival, continued racial disparities exist among children with Down syndrome. By age 20, blacks with this condition are still more than seven times as likely to die as whites. Similarly, while overall life expectancy has increased for most heart defects in past two decades, it still remains lower among blacks than among whites. From 1979-1997, deaths from heart defects overall declined 39 percent, but remained on average 19 percent higher among blacks than among whites. The reasons for these disparities are not clear.

Stillbirths are also more common in African-Americans than other groups. NCBDDD's pilot studies done in Atlanta and Iowa are developing systems to better characterize stillbirths. In 2007, NCBDDD entered into a contract with the Massachusetts Pregnancy to Early Life Longitudinal data system to improve the ability to conduct population-based studies of prevalence of stillbirths by gestational age, racial/ethnic variations in prevalence, maternal and fetal coexisting conditions, and recurrence risks. This may help our understanding of how disparities in preconception and prenatal care impact stillbirths.

While initial studies and health awareness activities on racial and ethnic disparities have been conducted, we are still looking for the causes of these disparities.

Ms. Roybal-Allard: What plans does the National Center on Birth Defects and Developmental Disabilities (NCBDDD) have to address racial and ethnic health disparities that persist among the special populations that it serves?

Dr. Gerberding: Dr. Gerberding: Racial and ethnic disparities are a priority for NCBDDD's efforts focused on infant mortality and birth defects. NCBDDD will continue a variety of activities targeting diverse ethnic and minority groups. For example, the program plans to focus on the potential of corn flour fortification as a means to reduce the occurrence of spina bifida and anencephaly among Hispanics. NCBDDD also plans to target American Indian/Alaskan Native women to prevent fetal alcohol spectrum disorders, which are more common among this population. NCBDDD is planning to adapt prevention interventions to reduce alcohol-exposed pregnancies, for example, to specifically address the needs of this high risk population.

There is much that can be done to better address racial and ethnic disparities. Building on existing investment, NCBDDD could expand the National Birth Defects Prevention Study to increase the number of Hispanic participants by enlarging the study area specifically in those sites such as Texas and California that have a large Hispanic population. This can also be expanded to include more African Americans and other racial and ethnic minority groups, helping us understand the causes of birth defects in these populations.

Furthermore, NCBDDD could add a longitudinal component to the National Birth Defects Prevention Study to study disparities in medical and other services and how they impact quality of life and survival.

Additional strategies could include conducting research to study the reasons for the wide disparity in survival rates for children with birth defects. Evidence suggests that initial studies should focus on issues related to quality and access to care. Providing access to prenatal care may help reduce stillbirths in certain populations. We know that some risk factors for having a stillbirth are higher in African-Americans. These include chronic underlying health conditions such as diabetes and hypertension; coupled with lack of access to care and health insurance. Targeted research is needed to understand the complex factors that interplay with social-economic status and access to care.

Ms. Roybal-Allard: Does NCBDDD need additional resources to achieve such plans?

Dr. Gerberding: Creating a strong foundation today would help scientists around the world understand the underlying reasons for the existence of these racial and ethnic disparities which in turn could help answer many questions and save future resources spent on lifelong medical treatments and supportive services for children and adults with birth defects. Targeted research would be able to understand efforts needed to change these disparities.

NATIONAL BIRTH DEFECTS PREVENTION STUDY

Ms. Roybal-Allard: The National Center on Birth Defects and Developmental Disabilities (NCBDDD) has been conducting the National Birth Defects Prevention Study at 9 Centers of Excellence for over 11 years and invested over \$85 million to find the causes of birth defects. Can you give the Subcommittee a brief update on this study?

Dr. Gerberding: CDC's nine Centers for Birth Defects Research and Prevention have collaborated on what is now the largest study of the causes of birth defects ever conducted in the US. Sites include universities and state health departments in Arkansas, California, Georgia (CDC), Iowa, Massachusetts, New York, North Carolina, Texas, and Utah. Researchers have gathered information from more than 29,000 families and are using this information to look at key questions to identify the causes of birth defects.

Most recently, study collaborators have discovered important findings on 1) nutritional factors, such as B vitamins, and the causes of certain birth defects; 2) chronic conditions, such as thyroid disease and diabetes, and the increased risk of birth defects; 3) medications commonly used to treat depression and the risk for birth defects; and 4) the relationship between risk factors, such as smoking and obesity, and certain birth defects. We have only begun to look at the possible wealth of data on birth defects from what is, in epidemiology, a very small sub-set of potential data. The potential impact on birth defects prevention from this study is tremendous.

Ms. Roybal-Allard: It is my understanding that with the current funding level the NCBDDD will have to reduce the number of Centers conducting this study and there will continue to be insufficient resources to analyze the thousands of DNA samples collected. Is this true?

Dr. Gerberding: In FY 2008, NCBDDD will fund 7 centers, which is a reduction of 2 centers compared to FY 2007.

Ms. Roybal-Allard: What impact will this have on the successful completion of the study and subsequent analysis of the data?

Dr. Gerberding: A decrease in the number of funded Centers will impact the capacity of the study by reducing the research and surveillance data used to identify new causes of birth defects and reducing the analytic capacity to evaluate this data. However, more than 100 research projects are currently in progress and have the potential to make major advances in our understanding of the causes of birth defects.

PUBLIC HEALTH EFFECTS OF CLIMATE CHANGE

Ms. Roybal-Allard: According to the American Public Health Association, there is a direct connection between climate change and the health of our nation. Yet few Americans are aware of the very real consequences of climate change on the health of our communities, our families and our children. What specific public health threats do you see as consequences of climate change?

Dr. Gerberding: Potential health risks include direct effects of heat, health effects related to extreme weather events, air pollution-related respiratory and cardiovascular disease, allergic diseases, water- and food-borne infectious diseases, vector-borne and zoonotic diseases, food and water scarcity, and mental health problems.

Ms. Roybal-Allard: Is the CDC engaged in any activities to prepare this country for the anticipated public health threats of climate change?

Dr. Gerberding: Yes, CDC is engaged in this issue and considers climate change a public health concern. As the nation's public health agency, CDC is uniquely poised to lead efforts to anticipate and respond to the health effects of climate change. Many of our existing programs and scientific expertise provide a solid foundation for such work:

- Environmental Public Health Tracking: CDC's Environmental Public Health Tracking Program has funded several states to build a health surveillance system that integrates environmental exposures and human health outcomes. Beginning in 2008, this system, the Tracking Network, will provide information on how health is affected by environmental hazards. The Tracking Network will contain critical data on the incidence, trends, and potential outbreaks of diseases, including those affected by climate change.

- **Disease Surveillance:** Preparing for climate change also involves working closely with state and local partners to document whether potential changes in climate have an impact on diseases transmitted through water, food, insects and animals. One such development is ArboNet, the national arthropod-borne viral disease tracking system. Currently, this system supports the nationwide West Nile virus surveillance system that maps cases in humans and animals, and would detect changes in real-time in the distribution and prevalence of cases. CDC's PulseNet tracking system also is uniquely designed to identify climate-related changes in the incidence of food- and water-borne diseases.
- **Geographic Information System (GIS):** CDC is applying GIS technology in unique and powerful ways, including public health responses to environmental hazards. It has been used in data collection, mapping, and communication to respond to issues as wide-ranging and varied as the World Trade Center collapse, avian flu, SARS, and Rift Valley fever. In addition, GIS technology was used to map issues of importance during the CDC response to Hurricane Katrina.
- **Modeling:** Model projections of future climate change can be used as inputs into models that assess the impact of climate change on public health. For example, CDC has conducted heat stroke modeling for the city of Philadelphia to predict the most vulnerable populations at risk for hyperthermia.
- **Health Protection Research:** CDC can promote research to further elucidate the specific relationships between climate change and various health outcomes, including predictive models and evaluations of interventions. CDC has conducted research on the relationship between hantavirus pulmonary syndrome and rainfall, as well as research assessing the impact of climate variability and climate change on temperature-related deaths and injuries.

In addition, CDC is also sponsoring a series of workshops exploring key dimensions of climate change and public health, including drinking water, heat waves, health communication, vector-borne and zoonotic diseases, and communities of color. The agency will also be launching an expanded climate change website in April during National Public Health Week, which is focused on climate change.

Ms. Roybal-Allard: Please provide us with your professional judgment as to the funding level that would be necessary to fill CDC's unmet needs in carrying out its public health mission to protect Americans from the anticipated public health threats of climate change.

Dr. Gerberding: While CDC's expertise and existing programs poise the agency to engage on climate change, we lack a formal climate change program. The following areas represent CDC's professional judgment in this area:

Internal CDC research and capacity building: \$3.0 million

- Formally establish a Climate Change program within NCEH
- Staff expertise to include epidemiology, infectious disease ecology, disaster preparedness, modeling and forecasting, climatology/earth science, communication, and others

- Support internal research
- Coordinate and manage resources across CDC to utilize broad range of expertise

Extramural sponsored research on climate change and public health: \$5.0 million

- Fund four to six academic Centers of Excellence at Universities, selected through competitive process
- Up to \$1.0 million in direct funding each year
- Research themes: forecasting and modeling; vector-borne diseases; climate change communication research; food-and water-borne diseases; vulnerable populations; heat waves; healthy urban design and transportation to minimize climate change impacts

Improve CDC Global Disease Detection: \$1.5 million

- Strengthen CDC's Global Disease Detection Centers around the world to monitor new infectious disease trends related to changed climates by improving outbreak response, global disease surveillance, and research
- Build capacity and improve quality of epidemiologic and laboratory science through better training programs

Outreach, communication, technical education: \$1.5M

- Disseminate technical information on the health effects of climate change and best approaches to preparedness, based on results of internal and extramural research
- Outreach to health professionals, state and local health departments, university environmental studies departments, science teachers, federal, state and local officials, community groups, faith-based organizations, industry, and the public, through multiple channels including partner organizations, websites, publications, workshops, and health campaigns

CDC contribution to Climate Change Science Program (CCSP): \$0.1M

- Represent HHS and contribute to scientific research for health issues related to climate change (CCSP integrates federal research on climate and global change sponsored by thirteen agencies)

TOTAL: \$11.1M

Note: This estimate does not factor in other competing priorities and was developed without fiscal constraints.

Ms. Roybal-Allard: Preventable injuries remain the leading cause of death and hospitalization for children in America. We literally spend tens of billions of dollars every year to provide health insurance to low-income children in this country, but CDC's injury prevention funding has essentially been flat funded the last three years, and this year the President's budget recommends a million dollar reduction in the program. What percentage of the injury prevention budget is devoted to childhood injuries?

Dr. Gerberding: The injury prevention and control FY 2008 appropriation of \$134.8 million has two lines dedicated specifically to childhood injury issues. The child maltreatment budget line is funded at \$7.1 million in FY 2008, and the youth violence prevention budget line is funded at \$23.2 million in FY 2008. These lines are specifically dedicated to the prevention of injuries among children and adolescents. Additionally, a portion of the unintentional injury budget is used to support projects that address childhood injury issues such as sports and recreational injuries, drowning prevention, child passenger safety seats, and traumatic brain injury among children.

Ms. Roybal-Allard: What activities is CDC engaged in to reduce the incidence of preventable injuries among children, and what successes have these activities had?

Dr. Gerberding: CDC engages in a number of activities designed to reduce the incidence of preventable injuries among children. With its child maltreatment prevention budget, CDC works to develop, evaluate, and disseminate evidence-based interventions that support and promote safe, stable, and nurturing relationships (SSNRs) with parents and other significant persons. An example of a recent activity in the area of child maltreatment prevention is Triple P, the Positive Parenting Program, a system of scientifically supported parenting programs implemented by CDC and the University of South Carolina. Evaluation data comparing the nine Triple P counties to nine control counties has demonstrated significant reductions in substantiated cases of child maltreatment, out-of-home placements resulting from child maltreatment, and child injuries suspected to be caused by maltreatment. CDC also works to disseminate and promote adoption of CDC's Uniform Definitions of Child Maltreatment and Recommended Data Elements through projects like the Model Child Maltreatment Surveillance project, in which three states are applying these definitions to assess the magnitude of child maltreatment mortality in their state. Additionally, the National Center for Injury Prevention and Control has identified child maltreatment prevention as one of its key priority areas, allowing the Injury Center to put an additional emphasis on this important issue in a variety of ways. Lastly, the Injury Center has convened meetings with partners in the areas of child maltreatment and youth violence prevention in the past two years, providing experts in these areas an opportunity to develop strategies, action plans, and consistent messaging in order to more effectively conduct prevention activities in these areas across the spectrum of local, state, and federal levels.

CDC also engages in youth violence prevention activities by working to develop, evaluate, and disseminate evidence-based interventions that create communities in which youth are safe from violence to ensure the development of youth into healthy adults. Through its youth violence prevention program, CDC and Carnegie Mellon University are evaluating the impact of an initiative to depopulate public housing communities in Pittsburgh on community levels of youth violence. Preliminary analyses indicate significant decreases in incidents of violent crime in the intervention community, with no corresponding increases in surrounding communities or in communities who absorbed families moving from the public housing community. Additionally, CDC assembled and convened a panel of experts to identify promotive and protective factors, links between promotive and protective factors and interventions, strategies for translating findings on

promotive and protective factors into policy, and next steps for research and practice. These experts were then engaged to compare findings across communities and populations to determine common promotive and protective factors. As a core set of factors is identified, it can be used to inform further prevention efforts in communities nationwide.

In the areas of sports and recreational injury prevention, CDC developed and disseminated two toolkits designed to educate various audiences on concussions among youths. The first, called “Heads Up: Concussion in High School Sports,” was released in 2005. Over 35,000 copies have been disseminated, and a one-year follow-up study found that: 38 percent of coaches reported making changes in how they deal with concussion, 50 percent of coaches reported viewing concussion more seriously; and 68 percent of coaches reported using the toolkit to educate others. The second toolkit – launched in 2007 in collaboration with 26 leading health, sports, and national organizations – is called “Heads Up: Concussion in Youth Sports.” More than 30 million media impressions resulted from this promotion, and more than 15,000 toolkits have been distributed to date.

Ms. Roybal-Allard: How can we better prioritize prevention for our nation’s children?

Dr. Gerberding: CDC is working to prioritize prevention for our nation’s children in a variety of ways. The establishment of goals related to each life stage has resulted in an action plan that identifies gaps in the public health system in terms of protecting and promoting children’s health. These action plans are blueprints for action, and CDC is working with its partners to address these gaps and move toward a more comprehensive strategy to prevent disease, disability, injury, and death among children.

MORTALITY DATA AMONG PUBLIC MENTAL HEALTH PATIENTS

Ms. Roybal-Allard: In 2006 your agency commissioned a study showing that patients who receive services in public mental health clinics die – on average – 25 years earlier than other Americans. What is even more alarming is that many of these patients die because of preventable chronic diseases, for which they never received even basic physical health care. What actions has SAMHSA taken to address this disparity in health care and life expectancy?

Dr. Cline: The disparity in health care and life expectancy is a significant public health challenge for the field to create new approaches to wellness and integration of behavioral health and primary care services.

In September, 2007, SAMHSA’s Center for Mental Health Services convened a National Wellness Summit for People with Mental Illness. The objective of this two-day meeting was to develop a coordinated and strategic action plan to promote wellness and reduce early mortality by convening multiple stakeholders including: representatives from Federal, State, County, mental health and primary care providers, researchers, consumers, families, funding agencies, accreditation bodies, advocates, and other groups.

The group identified a wide variety of potential factors that may contribute to this disparity, including rates of cardiovascular disease, diabetes, respiratory disease, infectious disease; risk factors due to high rates of smoking, substance abuse, obesity; increased vulnerability due to poverty, social isolation, trauma and incarceration; a lack of coordination between mental and primary healthcare; stigma and discrimination; side effects from psychotropic medications; and an overall lack of access to healthcare – particularly preventative care. In addition to the tragedy of early death, higher rates of acuity of health conditions result in greater health costs to the nation.

Addressing this issue requires action on a variety of fronts, including the following:

- Ongoing public health surveillance activities to help provide a more detailed understanding of the specific reasons for this disparity in life expectancy,
- Partnerships between mental health authorities and public health officials and State and local levels to communicate public health risk factors and integrate behavioral health and primary care services,
- Consumer information on wellness, including attention to risk factors that can impact life expectancy; and
- Developing efforts focused on the integration of behavioral health and primary care systems.

Some examples of surveillance activities already underway to address this issue include behavioral health surveillance through ongoing partnership with the Centers for Disease Control and Prevention to include mental health information in the Behavioral Risk Factor Surveillance System. The Center for Mental Health Services also assists State governments in incorporating this behavioral health risk surveillance information into existing data infrastructure to help inform policy priorities and service delivery at State and local levels. SAMHSA is also augmenting available mental health information in its National Survey on Drug Use and Health which provides information to inform Federal, State, and local policy priorities related to behavioral health needs.

In grant programs, SAMHSA's major first step in this area of wellness programs and behavioral health and primary care integration focuses on very young children. In FY 2008, SAMHSA received an appropriation of \$7,369,000 for a special wellness initiative. Based on Congressional mandate, this FY 2008 effort focuses on promoting wellness of children, birth to 8 years of age. The goal of this effort, known as Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), is to support Federal, State, Territorial, Tribes and locally-based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services.

In FY 2009, SAMHSA proposes the Mental Health Targeted Capacity Expansion Grants program to help community's bridge gaps in treatment services by expanding or enhancing a community's ability to provide rapid, strategic, comprehensive, integrated and creative, community-based responses to a specific, well-documented mental health capacity problems, including technical assistance. This program will foster the

provision of evidence-based treatment practices and will address the emerging mental health needs identified by States and local communities. This program focuses the resources to the most urgent needs of the communities and allows for the most efficient integration of primary care and behavioral health models.

Ms. Roybal-Allard: Is your agency partnering with HRSA to strengthen the capacity of community mental health organizations to provide primary care and specialty medical services for the mentally ill?

Dr. Cline: Yes, the Health Resources and Services Administration (HRSA) is a key organizational partner in the challenge of integrating behavioral health and primary care service systems. The Center for Mental Health Services has worked closely with health officials from HRSA in designing its first major grant initiative focused on integrating behavioral health and primary care systems—Project LAUNCH.

PANCREATIC CANCER

Ms. Roybal-Allard: In 2001, the National Cancer Institute developed a set of 39 recommendations for increasing pancreatic cancer research, including attracting more scientists to this field of study. But here we are, 7 years later, and only 5 of these recommendations have been implemented. Pancreatic cancer research currently receives less than 2% of NCI's budget, despite the fact that pancreatic cancer deaths are increasing. What concrete steps will you take to make this field of study a higher priority?

Dr. Zerhouni: NCI has identified and implemented initiatives in pancreatic cancer research as one of its strategic priority areas. Since the Pancreatic Cancer Progress Review Group report was published in 2001, NCI's investment in pancreatic cancer research has increased from \$21.8 million in FY 2001 to an estimated \$73.2 million in FY 2009, almost a 240 percent increase. Furthermore, the NCI investment in pancreatic cancer research grew at a much faster rate than the overall NCI budget. Additionally, the number of investigators with NCI-funded R01 grants has increased over 170 percent from 34 in 2000 to 92 in 2006. Over the same period, the number of pancreatic cancer research projects has grown almost 190 percent from 85 to 245.

NCI will sustain this momentum by continuing to invest. For example, NCI's major new initiatives -- including the NCI Alliance for Nanotechnology in Cancer and the Cancer Biomedical Informatics Grid (caBIG) -- hold a great deal of promise for improving and extending the lives of pancreatic cancer patients. NCI currently supports about 70 pancreatic cancer clinical trials, many of which are being conducted in partnership with other organizations.

These efforts created a strong infrastructure and cutting-edge scientific research program to study all aspects of pancreatic cancer including prevention, early diagnosis and therapy. It is expected that NCI's support of pancreatic cancer research and resulting science advances will continue to increase.

Ms. Roybal-Allard: We've seen how important early detection tests have been in reducing mortality for other cancers. How far away are we from finding an early detection test for pancreatic cancer?

Dr. Zerhouni: Commonly used imaging methods, such as endoscopic ultrasound, abdominal CT scan, or MRI, are inadequate for the detection of early stage pancreatic cancer. This has led to NCI's investment in a portfolio that includes multiple relevant early biomarker detection research projects. Sixteen early detection biomarkers for pancreatic cancer are in pre-validation studies with others rapidly being added to the validation pipeline.

CA 19-9 is presently the most widely used serum marker for pancreatic cancer, but as a screening test in an asymptomatic population, its positive predictive value is below 1%. EDRN investigators are actively exploring both genomic and proteomic markers to improve the ability to detect early stage pancreatic cancers.

In addition, at the University of Nebraska, EDRN investigators are working to improve the utility of CA 19-9 by adding a test to identify proteins associated with the CA 19-9 antigen. Using tissues from pancreatic patients retrieved using endoscopic ultrasound-guided fine needle aspirates, this group reported increased protein expression associated with specific genes. From these proteins they developed an antibody that can detect 91% of pancreatic cancer in tissues. They are currently working to develop assays to detect these proteins in serum.

Scientists at the University of Texas M. D. Anderson Cancer Center are also taking a targeted approach to identify biomarkers for early detection of pancreatic cancer by focusing on abnormal genetic pathways. They have identified a number of genes that are consistently differentially expressed in pancreatic cancer and are examining these genes as candidate biomarkers.

A protein array system to analyze blood samples from patients with pancreatic cancer is being used at the University of Pittsburgh Cancer Institute. These investigators are using the differences in protein expression they observed to distinguish pancreatic cancer patients from healthy controls to develop a 10-biomarker panel with a sensitivity of 87% and a specificity of 98%. This panel specifically recognized patients with pancreatic cancer and excluded patients with other cancers, including lung, esophageal, head and neck, ovarian, breast, endometrial and melanoma.

Another EDRN team at the Fred Hutchinson Cancer Research Center developed a panel of protein biomarkers in serum that can distinguish patients with pancreatic cancer from those with pancreatitis (inflammation of the pancreas) with nearly 95% sensitivity and specificity. Biomarker panels developed by both EDRN teams are very promising and plans are in progress to validate their findings using larger numbers of specimens, especially from early stage disease, collected from multiple sites.

Research into risk for developing pancreatic cancer began this year at NCI. The Pancreatic Cancer Cohort Consortium (PanScan) is a group of investigators scanning the genomes of 1,200 patients with different types of pancreatic cancer and 1,200 controls to find genetic markers that will identify people at risk of this disease. Subsequent validation study will analyze the most promising common genetic variants in the human genome linked to pancreatic cancer; with the promise of finding preventive interventions for people at increased risk of developing the disease.

While it is very difficult to estimate how far we are from a new diagnostic test, the peer-reviewed supported projects noted above are part of large activities that are relevant to reaching that goal.

Ms. Roybal-Allard: How much would you need to find a pancreatic cancer early detection test?

Dr. Zerhouni: In FY 2007, NCI spent \$73.2 million on pancreatic cancer research. Through this research NCI will continue to make progress in the understanding pancreatic cancer and finding ways to diagnosis the disease early. However, sustained resources including development of advanced technologies, new research projects, and a cadre of expert scientists working on the problem are critical to this effort. As noted above, NCI is supporting a number of early detection research initiatives and promising results have been realized. Investment in cancer research has never been more critical or more needed.

Ms. Roybal-Allard: How is the NCI prioritizing this effort given that pancreatic cancer is one of the deadliest forms of cancer and is currently the fourth leading cancer killer?

Dr. Zerhouni: NCI recognizes the importance of pancreatic cancer research efforts. For example, a pancreas state-of-the-science meeting was held at NCI in December of 2007 to bring together investigators and other stakeholders to develop a research agenda for adenocarcinoma of the pancreas over the next 3-5 years. Based on input from the meeting, the Gastrointestinal Scientific Steering Committee of the NCI Clinical Trials Working Group (CTWG), working with Cooperative groups and other groups that are active in pancreatic cancer clinical research, are developing strategic priorities for future clinical trials. Their recommendations will be disseminated to the relevant oncology, imaging and translational research communities.

In addition, the Pancreatic Cancer Research Map (<http://www.cancermap.org/pancreatic/index.jsp>) was recently developed as a tool for tracking pancreatic cancer research, clinical trials, and investigators. The map is a collaborative project between NCI, the Pancreatic Cancer Action Network (PanCAN), and the Lustgarten Foundation for Pancreatic Cancer Research. The map is designed to facilitate and expedite collaborations among researchers in the pancreatic cancer research community by helping them find related projects in pancreatic cancer research and

network with other researchers, and also to identify funding opportunities specific to pancreatic cancer research.

As mentioned above, NCI is also supporting major new initiatives -- including the NCI Alliance for Nanotechnology in Cancer, PanScan, and the Cancer Biomedical Informatics Grid (caBIG) -- which have great potential for advancing pancreatic research.

BEHAVIORAL RESEARCH IN THE NIH

Ms. Roybal-Allard: For several years now, this subcommittee has requested that NIH assign a home for basic behavioral research at the National Institute of General Medical Sciences (NIGMS). This same request was a recommendation of the National Academy of Sciences and of your own Director's Advisory Committee, but as far as I can tell, there has been no coordinated plan for basic behavioral research either within NIGMS or across the NIH institutes. How many NIH grants are devoted to basic behavioral research?

Dr. Zerhouni: In FY 2007, NIH support of basic behavioral and social science research totaled \$1.104 billion. The estimated support for this area of research in FY 2008 and 2009 is \$1.098 billion and \$1.092 billion, respectively.

Ms. Roybal-Allard: What steps are being taken this year to secure management for this important field of research at NIGMS?

Dr. Zerhouni: This year NIGMS released its strategic plan for FY 2008-2012, Investing In Discovery, (see <http://publications.nigms.nih.gov/strategicplan/index.htm>) reaffirming its commitment to support basic behavioral science research and training related to its other mission areas. These activities extend over five areas related to the Institute's basic biomedical science research mission: (1) basic behavioral research in model organisms; (2) computational modeling of human populations including behavioral and social factors; (3) studies of the efficacy of interventions in promoting research careers; (4) support of a range of behavioral and social sciences research at minority-serving institutions; and (5) predoctoral training at the interface of behavioral and biomedical sciences.

NIGMS has also made staff changes to initiate and coordinate efforts in this area. The Institute has hired a sociologist with a background in social science research and public health as Chief of the Office of Program Analysis and Evaluation and appointed a Special Assistant responsible for enhancing behavioral training programs. In addition, NIGMS continues to partner with other NIH Institutes and Centers as well as the Office of Behavioral and Social Sciences Research (OBSSR) and the Office of Portfolio Analysis and Strategic Initiatives (OPASI) to promote basic behavioral research.

Ms. Roybal-Allard: What portion of the FY09 budget proposed for NIGMS will be devoted to basic behavioral research?

Dr. Zerhouni: NIGMS plans to devote \$21.4 million of the \$1.092 billion FY 2009 President's Budget Request for basic behavioral research.

WOMEN AND STROKE

Ms. Roybal-Allard: I read with concern about a study led by a neurologist at the University of Southern California in Los Angeles finding that in recent year's stroke has tripled among middle-aged women because of the obesity epidemic. Please tell this committee what is currently known about the risk factors for stroke in women.

Dr. Zerhouni: Stroke is the third leading cause of death among women in the United States. In Fiscal Year 2007, the NIH spent \$340 million dollars on stroke research. Although the incidence of stroke is relatively low in younger women, oral contraceptive use and migraines are risk factors. An increased risk of stroke also is associated with late stages of pregnancy and the postpartum period. In older women, the risk factors are similar to those for men -- hypertension, atrial fibrillation, diabetes, high cholesterol, coronary heart disease, obesity (particularly abdominal obesity), and smoking. Postmenopausal hormone (estrogen plus progesterone) therapy is also associated with an increased stroke. In addition, sleep-disordered breathing is a potentially treatable emerging risk factor for stroke. Black women are at higher risk than white women.

While women as a group have a lower prevalence of stroke than men, the study you cite analyzed 1999-2004 data from a CDC national epidemiological survey and found that women aged 45 to 54 were more than twice as likely as men of similar age to report having experienced a stroke. For this age group, unique stroke predictors for women versus men included increased waist circumference and a history of coronary artery disease. In addition, researchers found that traditional vascular risk factors for stroke, such as blood pressure and total cholesterol, were found to increase at a greater rate in women between the ages of 35 and 64 years. Recently, this same research group presented a comparison of 1999-2004 and 1988-1994 survey data at an American Stroke Association (ASA) conference. According to an ASA press release, results showed that the prevalence of stroke among middle-aged women has increased over the last decade. Increases in obesity, as assessed by body mass index and waist circumference, seemed to account for the surge in stroke prevalence observed in women between the ages of 45 and 54.

Stroke risk may also be modified or compounded by co-incident conditions. For example, the Stroke Prevention in Young Women Study (SPYWS), funded by the National Institute of Neurological Disorders and Stroke (NINDS), the NIH Office of Research on Women's Health, the National Institute on Aging, the National Center for Research Resources, the Department of Veterans Affairs, and the CDC, recently showed that women that suffer from migraine with visual aura have 1.5-fold greater odds of having an ischemic stroke (those caused by blood clots.) Surprisingly, the risk was highest in women with no prior history of high blood pressure, diabetes or heart attack.

Stroke risk factors such as smoking and the use of oral contraceptives, however, increased the risk further, placing women with all three risk factors at 7-fold higher odds of having a stroke than women without any risk factors.

Ms. Roybal-Allard: Is NIH engaged in any research looking at prevention strategies for obesity and stroke?

Dr. Zerhouni: Because obesity has risen to epidemic levels and greatly increases risk for many diseases and disorders, the NIH supports a spectrum of basic, clinical, and translational research on obesity, including research on strategies for obesity prevention and weight loss. This research includes studies focused specifically on women, as well as on both genders, and prevention studies for children and adolescents. For example, the NHLBI supports the Weight Loss Maintenance trial, which recently demonstrated successful strategies for adults to sustain weight loss. NHLBI also supports Girls Health Enrichment Multi-site (GEMS) Studies. Two recently-completed GEMS, tested approaches to preventing excess weight gain in African-American girls aged 8 to 10 at high risk for adult obesity. One of them found favorable changes in blood lipids, but no significant effect on obesity while the other found a significantly reduced BMI level in the intervention compared with the usual care group.

Additionally, because obesity is a strong risk factor for type 2 diabetes, which in turn increases risk for stroke, NIH-supported research on diabetes prevention and on improving the diet and physical activity of those with type 2 diabetes may also ultimately reduce stroke. For example, the Look AHEAD clinical trial, supported by the NIDDK and other NIH components, is examining the impact of an intensive lifestyle intervention to achieve and maintain weight loss over the long term in overweight adults with type 2 diabetes and on the incidence of heart attack, stroke, and cardiovascular-related death. Another effort, the HEALTHY study, supported by NIDDK, is determining whether changes in school food services and physical education classes, along with activities to encourage healthy behaviors, lower risk factors for type 2 diabetes in youth.

Many NIH-funded stroke prevention studies also address obesity or some of its co-morbidities. For example, the NINDS funds the Insulin Resistance Intervention after Stroke Trial (IRIS). Insulin resistance (IR), a condition in which the body does not respond properly to normal amounts of insulin and which has been associated with obesity, increases the risk of stroke. The IRIS trial will examine the efficacy of the drug pioglitazone in decreasing the risk of stroke or heart attack in individuals with IR. NINDS is also collaborating with the NHLBI and NIDDK in the Systolic Blood Pressure Intervention Trial (SPRINT) to determine if lowering blood pressure below the current recommended level decreases the risk of heart disease, renal failure and stroke. Finally, NINDS and NHLBI are jointly organizing a workshop for community health promotion experts to discuss key factors needed to institute behavior changes that will lead to improved health among people at risk for cardiovascular disease and stroke.

NIH also recognizes that stroke prevention and intervention strategies must be developed, tailored, and studied in a variety of populations. NINDS funds several large

scale studies focused on these goals. For example, the Reasons for Geographic and Racial Differences in Stroke (REGARDS) epidemiological study will help discern the contribution of different stroke risk factors and identify areas of focus for clinical or behavioral interventions for different populations. The NINDS also supports the Northern Manhattan Study (NOMAS), which has identified obesity, diabetes, hypertension, and vascular disease as strong stroke risk factors in a Hispanic American population. NOMAS researchers are eager to find predictive determinants for the association between obesity and stroke in order to better target people with excess weight that are at higher risk for stroke. Finally, the NINDS has recently made an award for a Stroke Disparities Program to Georgetown University, which will explore the impact of multilevel educational interventions for preventing acute stroke as well as more aggressive community-based patient management strategies for preventing recurrent stroke in the Washington D.C. area.

NIH BEHAVIORAL RESEARCH FOR HIV PREVENTION

Ms. Lee: Thank you Dr. Zerhouni for your testimony. This question is related both to NIH and CDC, so you and Dr. Gerberding can both answer.

Most of the HIV prevention programs that CDC funds are based on behavioral research carried out by the NIH.

The CDC recently released its Updated Compendium of Evidence-Based Interventions that are considered the best interventions for HIV prevention programs.

My understanding is that not a single abstinence program was included on this list. That's correct is it not?

Dr. Gerberding: The *Updated Compendium of Evidence-Based Interventions* focuses on HIV prevention interventions that have been formally evaluated and shown to reduce the risk of HIV transmission. The interventions included in the *Compendium* are intended for use with HIV-infected individuals or populations at high risk for HIV infection, such as men engaging in unprotected anal sex with other men, heterosexually active adults in non-monogamous relationships, injection drug users, and sexually active youth living in areas with high STD rates. These interventions are not intended for use with the general public or with populations not at high risk of HIV infection. To that end, studies were not included in the *Compendium* if they did not focus on high-risk populations or populations disproportionately affected by HIV.

It should be noted that CDC continues to promote abstinence as the only way to completely avoid risk of HIV. This is reflected in training and technical assistance provided by CDC on these interventions.

Dr. Zerhouni: The CDC developed the Updated Compendium of Evidence-Based Interventions with Evidence of Effectiveness. As NIH did not develop the Compendium, I am unable to address this question.

Ms. Lee: The compendium includes 49 evidence based interventions, yet only 4 were newly identified for the MSM community, who account for about 50 percent of new infections in the US.

None of the interventions are primarily focused on Black MSMs and none focus on Latino MSMs, two groups disproportionately affected by HIV/AIDS. In their report accompanying the new compendium, even the CDC pointed this problem out saying:

“Although it is encouraging that many efficacious interventions identified in our review target important populations, several gaps still remain. Some of the populations hardest hit by the HIV/AIDS epidemic or at greatest risk of infection or transmission were not represented. These populations include African American, Hispanic, and other MSM of color; young

MSM, particularly young African American and Hispanic MSM; substance-using MSM; transgender persons; HIV-positive intravenous drug users; and rural populations. The identification of effective intervention approaches with these populations should be accorded the highest priority in future research.”

What accounts for the lack of approved interventions for the MSM community and what are you doing to address this?

Dr. Gerberding: The efficacy review that CDC conducted to select interventions for the *Updated Compendium* is a reflection of the HIV prevention research field. The small number of evidence-based interventions for men who have sex with men (MSM) is a reflection of the relatively small number of scientific publications evaluating HIV behavioral interventions for MSM. The *Updated Compendium* reviewed the scientific literature published from 1988 through 2005. At that time 10 percent of the total number of scientific publications reviewed for the *Compendium* targeted MSM; the other 90 percent targeted other risk groups. As a result, 4 of the 49 evidence-based interventions (EBIs) listed in the *Updated Compendium* targeted MSM, and another 4 of the 49 EBIs targeted HIV-positive individuals where a majority of the study sample was MSM (ranging from 61 percent to 76 percent of the study sample). Given the scientific findings were based on such a large proportion of MSM, we are also recommending these 4 interventions be used with HIV-positive MSM populations. We do not have the information to know how much of the current intervention evaluation research is being directed towards MSM, but the number of scientific publications for MSM is small relative to other risk groups.

Because of the gap in research for MSM and the small number identified EBIs for MSM, CDC recommends that its prevention partners and grantees adapt other proven interventions to meet the needs of their local MSM community. Please note that the *Updated Compendium* currently only focuses on individual-level and group-level interventions. CDC is currently reviewing community-level interventions (CLIs) for inclusion in future updates. In addition, CDC continues to recommend that prevention programs use 3 CLIs for MSM that were in the previous *Compendium*. These interventions were identified using different criteria (less rigorous criteria that were more appropriate a decade ago when the *Compendium* was published) and are recommended for use until stronger CLIs are identified.

CDC strongly supports additional research to identify more efficacious interventions for the MSM community. CDC is funding several feasibility studies to develop and pilot test new HIV behavioral interventions for MSM populations and is also funding several small-scale experimental trials to evaluate whether previously developed HIV behavioral interventions are suitable for use with MSM.

Finally, HIV testing is also an intervention found to change behavior. Individuals aware of their HIV status can access care and treatment to protect their health, and those

who are aware of their infection are much more likely to take steps to protect their partners.

Dr. Zerhouni: The NIH conducts and supports biomedical and behavioral research on all aspects of HIV prevention. The CDC considers the outcomes of studies in developing recommendations included in the Compendium. NIH supports a diverse portfolio of research studies to identify prevention strategies for a multiplicity of high-risk individuals, including men who have sex with men, transgender persons, women, substance users, and adolescents, persons from racial and ethnic populations, in geographically diverse settings. This research is challenging and must take into account complex social and cultural differences. As with any scientific study, rigorous research may not always yield desired outcomes.

Ms. Lee: What about for transgender persons, HIV positive intravenous drug users or rural populations? Are you conducting research on these important areas?

Dr. Gerberding: There are currently no evidence-based interventions (EBIs) identified from the scientific literature for these three populations. Very little of the scientifically published intervention evaluations has focused on transgender persons (0.7 percent of the literature), HIV-positive intravenous drug users (IDUs) (1.4 percent of the literature), and rural populations (2 percent of the literature). CDC recently tested an intervention for HIV-positive IDUs but it was not found to be efficacious. Given the gap in research for these populations, CDC recommends prevention agencies adapt other proven interventions to meet the needs of their local populations. This is particularly appropriate for transgender and rural populations because intervention trials research is challenging with these groups because of smaller population size (transgender) and geographic dispersion (rural populations).

In addition, despite not meeting the criteria required for inclusion in the *Updated Compendium*, the strongest behavioral interventions for HIV-positive IDUs identified in the literature have been made available to prevention partners to implement in their communities until an intervention with stronger evidence is identified. CDC is currently funding several feasibility studies to develop and pilot test new HIV behavioral interventions and several evaluations of adapted interventions for transgender persons as well as other populations not well represented in the *Updated Compendium*.

Ms. Lee: How are we going to address prevention in the US if we don't have approved interventions for the communities that are most impacted by the epidemic? Do you work with the CDC on setting your research priorities?

Dr. Gerberding: CDC has focused on making interventions available for the most in-need communities since the beginning of the epidemic. All identified interventions address high-risk populations, and 39 of 49 interventions address people of color, groups disproportionately impacted by HIV and AIDS. By allowing our evidence-based interventions (EBIs) to be adapted to meet the needs of a variety of very specific target populations, we are greatly expanding the ability of our prevention work force to meet

the HIV prevention needs of our country. Adaptation allows communities to tailor EBIs to meet their specific needs in terms of gender, race, sexual orientation, geography, cultural practices, and other populations. CDC actively supports adaptation efforts in both its program and research activities which allows for much broader coverage of the highest risk populations in the U.S.

In addition, as previously mentioned, individuals aware of their HIV status can access care and treatment to protect their health, and those who are aware of their infection are much more likely to take steps to protect their partners.

Yes, CDC works with NIH on setting research priorities. For example, on October 17-18, 2007, CDC, NIH, and the Health Resources and Services Administration (HRSA) convened a collaborative research consultation in Atlanta, Georgia. The purpose of the consultation was to formulate novel intervention strategies to address the HIV/AIDS epidemic among African Americans, with a focus on new strategies and current effective strategies that should be more widely disseminated. Twenty HIV/AIDS prevention researchers, health services researchers and providers were invited to serve as participants. As a follow-up to this meeting, CDC, NIH, and HRSA are working together to produce a theme issue of the *American Journal of Public Health* focusing on HIV prevention interventions for African Americans. Papers are being submitted in spring 2008 for a December 2008 release date. CDC is also an active collaborator on a current National Institutes of Mental Health (NIMH) led effort to support operational research that seeks to further improve the effectiveness of HIV prevention programs in real-world settings. It is expected that this collaborative effort will result in research that further enhances the transfer, dissemination, and implementation of effective evidence-based HIV-prevention in the United States.

In addition, on April 24, 2007, CDC leaders met with NIH leaders to discuss potential areas of research collaboration.

Dr. Zerhouni: NIH, through the Office of AIDS Research (OAR), develops an annual trans-NIH strategic plan for all HIV/AIDS research activities that establishes scientific priorities. The *Trans-NIH Plan for HIV-Related Research* is developed through a unique, comprehensive, rigorous, and collaborative process involving representatives from NIH ICs and other federal agencies, including the Centers for Disease Control and Prevention, the Veterans Administration, United States Agency for International Development, Department of Defense, and SAMSHA; non-government experts from academia, foundations, industry; and community representatives. The Office of AIDS Research Advisory Council, which provides ongoing advice and guidance on NIH AIDS research, also includes a senior CDC staff member as an ex-officio member.

The NIH planning process has identified HIV prevention research as the highest priority for AIDS research. In addition to behavioral strategies, NIH supports a comprehensive portfolio of prevention research, including basic and clinical research of vaccines and microbicides, prevention of mother-to-child transmission, pre- and post-exposure prophylaxis, circumcision, and other interventions. These prevention studies

target specific at-risk populations on an individual, small group, and community level. For example, NIH supports a comprehensive portfolio to develop interventions for drug and other substance users. NIH research established that drug abuse treatment can reduce HIV transmission behaviors. Current research includes an NIH-supported research project to examine the barriers that African-American and Hispanic intravenous drug using couples encounter in securing HIV risk reduction interventions and drug abuse treatment. A number of NIH projects are elucidating risk factors for transgender individuals to inform the development of specific interventions for this group. NIH also supports studies targeting rural areas of the U.S. For example, an NIH study is testing a telephone peer-counseling intervention for HIV-infected women in rural southeastern U.S. Additional studies are investigating targeted group interventions for rural African-American cocaine users as well as a study focused on rural Latino MSMs in the southeast U.S.

CDC'S HEIGHTENED RESPONSE TO HIV/AIDS AMONG AFRICAN AMERICANS INITIATIVE

Ms. Lee: Dr. Gerberding, thank you for your testimony. It is good to see you again.

I also want to thank you for agreeing to come out to my district later in May to help us organize a community and provider meeting on the impact of HIV/AIDS on the African American community.

I understand our staff's are working on organizing the event now, and I look forward to seeing you again in Oakland.

In March 2007, a year ago, CDC announced its Heightened Response to HIV/AIDS among African Americans. Can you please give the committee an update on progress with respect to this initiative?

Dr. Gerberding: Over the past year, CDC has made significant achievements in engaging communities, leaders, public figures, and numerous organizations and sectors to mobilize a Heightened National Response (HNR) to the Crisis of HIV/AIDS among African Americans. At a meeting in March 2007, many leaders (in sectors including arts and entertainment, business, civic/social, education, elected officials, faith, health, and media) made commitments to reduce the burden of HIV/AIDS among African Americans. As of February 2008, 82 percent of the commitments made had been completed or acted upon. The commitments include developing and conducting awareness, communication, and testing programs, with the goal of reducing the burden of HIV/AIDS in African-American communities. CDC will reconvene to celebrate our collective commitment and honor these leaders and the progress made at a meeting on May 29-30, 2008, at the Morehouse School of Medicine's National Center for Primary Care in Atlanta, Georgia. New leaders continue to join this important effort and will be invited to this May event as well.

In addition to commitments made by HNR leaders, CDC awarded \$35 million in funding to state and local health departments to increase HIV testing opportunities among populations disproportionately affected by HIV, primarily African Americans. Twenty-three states and major metropolitan areas received awards ranging from \$690,000 to \$5.4 million. This program seeks to test more than 1 million people with the primary goal of identifying identify more than 20,000 people who are unaware that they are infected, allowing them to seek care for their own health and take steps to protect their partners. The program also aims to increase early HIV diagnosis and entry into care among African Americans. As part of CDC's commitment to accelerate progress in reducing HIV among African Americans, the program is targeted to areas of the nation in which African Americans have been most severely affected.

CDC SPENDING ON MSM HIV PREVENTION PROGRAMS:

Ms. Lee: Given that Men who have sex with Men account for nearly 50 percent of all new HIV/AIDS diagnosis in our country, why is CDC's prevention programs by state health departments only spending 21 percent of its money on this population?

People often ask why the rate of infections is going up in some populations, but it seems the CDC is not spending its money on where the epidemic is.

Shouldn't the CDC be encouraging state health departments to spend more of its prevention money on the MSM epidemic?

Dr. Gerberding: The FY 2005 budget data from state health departments show that 30 percent of HIV prevention resources do not target a specific risk population, but some are undoubtedly used for services for MSM. Nonetheless, CDC is concerned that prevention dollars are not allocated consistently across jurisdictions and may not in all cases be allocated according to the distribution of HIV among populations.

Also health departments are not the only source of funding to reach MSM and other at risk populations. Two CDC program announcements target prevention services to MSM and MSM of color. The first, "HIV Prevention Projects for Directly Funded Community-Based Organizations" funds 66 community-based organizations (CBOs) that target HIV prevention services to MSM. The second, "HIV Prevention Projects for Young Men of Color who Have Sex with Men and Young Transgender Persons of Color" targets this population up to age 24 at high risk for HIV infection.

In FY 2009, CDC is exploring ways to encourage health departments to target resources more in line with the HIV/AIDS epidemic but consistent with HIV prevention community planning guidelines.

CDC HIV TESTING RECOMMENDATIONS

Ms. Lee: The CDC has issued recommendations that everyone receive a voluntary routine HIV test from the ages of 13 to 64 when they encounter the healthcare system.

Can you provide us with an update on how this is being implanted, particularly as it relates to paying for the tests and performing the tests and associate counseling? What is the CDC doing to address this reimbursement issue?

Dr. Gerberding: Since publishing its *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings* in 2006, CDC has engaged in intensive efforts to assist stakeholders in routinizing HIV screening in health-care settings. These efforts include implementing the President's domestic HIV testing initiative with an initial \$45 million in 2007. Funding was used to support testing in 23 jurisdictions with high rates of AIDS among African Americans. We estimate that these jurisdictions account for 80 to 85 percent of AIDS cases among African Americans. CDC plans to fund these efforts again in 2008.

CDC is also developing venue-specific guidance to assist health care facilities in implementing the recommendations. Guidance is currently under development for STD clinics, correctional facilities, and community health centers. Guidance for emergency departments (originally developed by the Health Research & Educational Trust) is being updated.

In addition, CDC is providing training to providers on implementing HIV screening for health-care providers and ancillary/administrative staff at health-care settings through the 12 regional AIDS Education and Training Centers. As of February 2008, CDC had conducted 750 trainings nationwide for 10,000 clinicians and ancillary/administrative staff.

Please note that CDC's revised recommendations encourage providers to de-link testing and counseling to make routine HIV screening feasible in busy medical settings where it previously was impractical. Making the HIV test a routine part of care for all Americans is an important step toward removing the stigma still associated with testing.

Ms. Lee: Are private insurance companies paying for routine HIV testing?

Dr. Gerberding: Reimbursement for HIV testing by private insurance varies widely. Aetna, Humana, and Kaiser Permanente have announced support for CDC's recommendations through updated clinical policy bulletins for reimbursement consistent with CDC's *Revised Recommendations*. The American Academy of HIV Medicine supports reimbursement for routine HIV testing by private insurance companies, and the Academy's Committee on Reimbursement includes representation from America's Health Insurance Plans (AHIP).

Ms. Lee: What about Medicaid programs?

Dr. Gerberding: Policies for reimbursement for routine HIV testing by Medicaid are determined by the states. CDC has not assessed coverage in all states, but New York and California have both announced explicit policies for Medicaid reimbursement for HIV screening.

STATUS OF TESTING INITIATIVE

Ms. Lee: The announcements we have seen from CDC indicate that as many as 1.5 million African Americans will be tested for HIV per year through the state and local jurisdictions participating in this initiative. What is the status of this testing activity?

Dr. Gerberding: Launched in 2007, the President's Domestic HIV Testing Initiative seeks to improve the health of HIV-infected persons and decrease HIV incidence by increasing the proportion of persons who are aware of their HIV infection. Through this initiative, CDC will test between 1 – 2 million persons per year, with the primary goal of increasing early HIV diagnosis in jurisdictions with a high burden of AIDS among disproportionately affected populations. HIV testing provides a critical pathway to prevention and treatment services to prolong the lives of those infected and help stop the spread of HIV in the hardest hit communities across the United States.

In late 2007, CDC awarded \$35 million to 23 jurisdictions representing 80-85 percent of the reported annual new cases of AIDS among African Americans. The project period of these grants is up to 3 years.

On January 31 - February 1, 2008, CDC held a grantee meeting in which all 23 of the funded jurisdictions were represented. The purpose of the meeting was to provide grantees with an overview of the announcement's programmatic information requirements and expectations; CDC's program monitoring role and responsibilities; and reporting and evaluation guidelines.

In 2008, CDC will continue to support these 23 jurisdictions. In 2008 and 2009, CDC will also support awards to states eligible for the Early Diagnosis Grant program. Funds for the Early Diagnosis Grant program will be used for testing and referral, partner counseling and referral services, perinatal HIV prevention, and HIV testing services in STD clinics and drug treatment centers.

COORDINATION WITH RYAN WHITE HIV/AIDS PROGRAMS

Ms. Lee: Five percent of SAMHSA's Substance Abuse Prevention & Treatment State Block Grant is reserved for HIV/AIDS programs. Can you tell us how these programs relate with Ryan White HIV/AIDS programs in the states and on the ground? Does SAMHSA require its grantees to coordinate their substance abuse programs with Ryan White grantees?

Dr. Cline: Title XIX, Part B, Subpart II of the Public Health Service Act (42 USC 300x-28(c)), "Coordination of Various Activities and Services," and the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.132 (c)), "Additional Agreements," require States to "...coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services)."

SAMHSA's Center for Substance Abuse Treatment has surveyed the States regarding how the States planned and carried out the requirements of Title XIX and the Interim Final Rule regarding Early Intervention Services for HIV. The surveys were conducted during 1999 and 2005, respectively.

The surveys are designed to gather information about services and results not uniformly captured in States' Uniform Application for the SAPT Block Grant. The survey covered HIV/AIDS services funded by the set-aside for Early Intervention Services for HIV as well as other sources.

The report includes a description of the planning processes implemented by States to encourage substance abuse treatment providers to participate in HIV planning processes and the nature of the relationship, if any, between Single State Agencies for Substance Abuse Services (SSA) and three HIV planning entities: (1) HIV Prevention Community Planning (HPCP) Groups required of all jurisdictions receiving HIV prevention funding from the Centers for Disease Control and Prevention (CDC); (2) Title I Planning Councils mandated by the Ryan White CARE Act; and (3) Title II Consortia mandated by the Ryan White CARE Act.

Table II-3 and Table II-4 describe collaboration activities between the Single State Agencies for Substance Abuse Services and State and local public health agencies responsible for HIV/AIDS services.

Table II-3. Activities Initiated by the SSA in the Past 12 Months to Encourage Substance Abuse Treatment Providers to Participate in Any HIV Planning Process

	All Respondents (n=51)	Set-Aside Respondents (n=21)	Non-Set-Aside Respondents (n=30)
Meeting(s) with the State HIV/AIDS agency	58.8%	71.4%	50.0%
Meeting(s) with Health Departments at the Local Level	17.6%	19.0%	16.7%
Meeting(s) with HIV Service Providers	39.2%	52.4%	30.0%

	All Respondents (n=51)	Set-Aside Respondents (n=21)	Non-Set-Aside Respondents (n=30)
Meeting(s) with the SSA intermediaries (regional authorities, districts, community service boards)	11.8%	9.5%	13.3%
Dissemination of information to HIV service providers regarding substance abuse treatment services	41.2%	42.9%	40.0%
Dissemination of information to substance abuse treatment providers regarding HIV services	56.9%	66.7%	50.0%
Joint communique(s) from both State SSA and HIV/AIDS Agency to substance abuse treatment and HIV service providers	13.7%	23.8%	6.7%
No Activities Initiated by SSA	13.7%	4.8%	20.0%
Unknown/Unsure	0.0%	0.0%	0.0%
Other	3.9%	4.8%	3.3%

Table II-4. Formal Relationship between SSAs and HPCP Groups over the Past 12 Months

	All States (n=51)	Set-Aside States (n=21)	Non-Set-Aside States (n=30)
Respondents that reported at least one type of formal relationship included in the survey (including "Other")	60.8%	71.4%	53.3%
No relationship between SSA and HPCP Group(s)	33.3%	28.6%	36.7%
Unknown	5.9%	0.0%	10.0%

For all discretionary grants funded under the SAMHSA/CSAT TCE/HIV Program, applicants are encouraged to demonstrate planning and coordination of services at the local level with the Single State Agency for Substance Abuse (SSA), and where applicable, Health Resources and Services Administration (HRSA) Ryan White Planning Councils and their approved service providers.

DIABETES

Mr. Udall: Dr. Gerberding, let me read some numbers and statistics. About 176,500 people aged 20 years or younger have diabetes. This represents 22 percent of all people in this age group. About one in every 400 to 600 children and adolescents has type 1 diabetes. In 2006, only four states had a prevalence of obesity less than 20 percent. Twenty-two states had prevalence equal to or greater than 25 percent; two of these states had a prevalence of obesity equal to or greater than 30 percent. 25.6 million adults in the general population have diagnosed heart disease. 39 percent of adults engage in no leisure-time physical activity. 17 percent of kids between the ages of 12 and 19 are overweight. 19 percent of kids between 6 and 11 are overweight. 15.7 million adults in the general population currently have asthma. 6.8 children currently have asthma.

I could go on, but let me read you some numbers now from your CDC budget justification.

Heart Disease and Stroke funding reduced by \$1.2 million dollars, Diabetes funding reduced by \$250 thousand dollars, Cancer Prevention and Control reduced by \$7.7 million dollars, Arthritis funding reduced by \$100 thousand dollars, Nutrition Physical Activity and Obesity funding cut by \$170 thousand dollars, Health Promotion funding cut by almost \$5 million dollars, Oral Health reduced by \$50 thousand dollars, the REACH program that addresses minority health problems reduced by \$140 thousand dollars, STEPS to a Healthier US reduced by almost \$10 million dollars. Dr. Gerberding, please explain to me the disparity in the increasing prevalence of preventive disease with the decreased commitment from the administration for prevention and health promotion programs.

Dr. Gerberding: Chronic diseases, including heart disease and stroke, cancer, and diabetes account for 7 of every 10 deaths in the United States each year. Furthermore, the long course of illness and disability from diseases such as heart disease and stroke, cancer, diabetes, and arthritis result in poor quality of life and disability for millions of Americans.

Over the past decade, CDC has developed a strong science base for our chronic disease programs. We know that effective prevention measures for chronic disease exist and that they will work. These include the use of early detection practices for cancer, diabetes, and heart disease and stroke; school health education programs, supportive environments for physical activity and healthy eating in communities, and establishment of standards for preventive care practices. For example, several clinical trials have provided evidence that type 2 diabetes can be prevented through lifestyle and behavior change. With 54 million Americans at very high risk for developing type 2 diabetes, this nation has the opportunity to apply the current science base to significantly reduce or stop the onset of diabetes and concurrently reduce the burden of this costly chronic disease. For children born in 2000, the lifetime risk for developing diabetes is one in three. Primary prevention of diabetes must be an important priority for the nation.

The Steps Program is an integral part of CDC's response to the epidemics of obesity and chronic disease. Through the Steps Program, local communities are implementing evidence-based interventions in community, school, workplace, and health care settings and make the critical local changes necessary to prevent chronic diseases and their risk factors. Special focus has been directed toward populations with disproportionate burden of disease and lack of preventive services. Steps communities have produced positive results, including: reducing obesity through community-based interventions, reducing chronic disease risk factors and health care costs in workplaces; creating healthier school environments including smoking bans, provision of nutritious foods, and physical activity enhancements; implementing clean indoor air ordinances; and reducing blood sugar levels among diabetes patients.

The FY 2009 Budget Request for the Steps Program is \$15.5 million, a \$9.6 million decrease from FY 2008. The Steps program is changing the grant structure in FY 2009 and anticipates funding 50 Steps Community Grants. The current funding announcement incorporates the lessons learned from the Steps demonstrations and will focus on more broadly disseminating interventions, through a redesigned program to have a greater impact on the health of our Nation's communities. Tools, resources, and training will be provided to community leaders and public health professionals to equip these entities to effectively confront the realities of the growing national crisis in obesity and other chronic diseases in their communities. In addition, lessons learned, models, and tools for local action to prevent chronic diseases will be disseminated to funded and non-funded communities to broaden the reach of the program across the nation.

The FY 2009 President's Budget Request maintains CDC's efforts in Chronic Disease Prevention and Health Promotion Programs at more than \$800 million.

HEALTH CARE

Mr. Udall: Dr. Gerberding, at a very illuminating hearing this morning on improving access to health care, my colleague Congressman Ryan asked one of the witnesses about estimates on how many dollars are saved per dollar invested in prevention and health promotion. Do you have any calculations on this?

Dr. Gerberding: CDC is committed to efficient and effective investments in prevention and health promotion. As an agency, we base our work on extensive science, evaluation and research. While most prevention and health promotion programs do not recover the intervention costs associated with avoided health care costs, they do provide positive returns with regards to improved health and benefits to the economy. The following are two examples of prevention programs that save more in avoided health care costs than the initial investment in prevention:

An economic evaluation of the impact of seven vaccines [Diphtheria Tetanus acellular Pertussis (DTaP), Tetanus diphtheria (Td), Haemophilus influenzae type b (Hib), inactivated poliovirus, measles mumps rubella (MMR), hepatitis B (Hep B), and varicella] routinely given as part of the childhood immunization schedule found that

vaccines are tremendously cost effective. Routine childhood vaccination with these seven vaccines, which prevent nearly 14 million cases of disease and over 33,000 deaths over the lifetime of children born in any given year, resulted in annual cost saving of \$9.9 billion in direct medical cost and an additional \$33.4 billion in indirect costs.

Source; Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States; *Archives of Pediatrics*; 159:1136-1138; December 2005,

Mr. Udall: The witness this morning mentioned that some studies on wellness programs offered by employers result in \$3 dollars saved per \$1 dollar invested. My question to you, though, is, have you guys run any calculations on the number of additional dollars that will be spent per dollar cut out of this CDC prevention and health promotion budget?

Dr. Gerberding: CDC is committed to efficient and effective investments in prevention and health promotion. As an agency, we base our work on extensive science, evaluation and research. Here are a few examples of what we do know about the costs of cutting prevention activities.

The resurgence of measles in 1989–1991 in the United States, which included a series of outbreaks that contributed to 43,000 cases and more than 100 deaths, primarily among children younger than 5 years of age, is a constant reminder that the presence of vaccines alone is not sufficient to protect populations against vaccine-preventable disease. Outbreaks can emerge swiftly and unexpectedly during times of complacency if vaccines are not accessible to those who are most vulnerable to infectious disease. The absence of adequate measurement tools and appropriate community assessment studies can result in reduced vigilance within the health care system if missing data foster mistaken beliefs that national or local immunization rates are up to date. Measles, once a common childhood disease in the United States, can result in severe complications, including encephalitis, pneumonia, and death. Because of successful implementation of measles vaccination programs, endemic measles transmission has been eliminated in the United States and the rest of the Americas. However, measles continues to occur in other regions of the world, including Europe. In January 2008, measles was identified in an unvaccinated boy from San Diego, California, who had recently traveled to Europe with his family. After his case was confirmed, an outbreak investigation and response were initiated by local and state health departments in coordination with CDC, using standard measles surveillance case definitions and classifications. Results of an investigation have identified 11 additional cases of measles in unvaccinated children[†] in San Diego that are linked epidemiologically to the index case.

Measles virus is highly infectious; vaccination coverage levels of >90 percent are needed to interrupt transmission and maintain elimination in populations. The ongoing outbreak in Switzerland has occurred in the context of vaccination coverage levels of 86 percent for 1 dose at age 2 years and 70 percent for the second dose for children aged <12 years. In the United States, vaccination coverage rates for at least 1 dose of MMR vaccine at 19-35 months of age have been greater than 90% for at least a decade. Second

dose coverage, although not routinely measured nationally, is even higher due to state school entry requirements. The measles outbreak in San Diego was among unvaccinated preschool and school aged children in a community with a high rate of personal belief exemption for vaccination. These exemptions are defined differently for each state.

According to a 2005 study, without routine vaccination, direct and indirect costs of diphtheria, tetanus, pertussis, *H influenzae* type b, poliomyelitis, measles, mumps, rubella, congenital rubella syndrome, hepatitis B, and varicella would be \$12.3 billion and \$34.3 billion, respectively. Direct and societal costs for the vaccination program at that time were an estimated \$2.3 billion and \$.5 billion, respectively. Direct and societal (includes direct and indirect costs) benefit-cost ratios for routine childhood vaccination were 5.3 and 16.5, respectively. ⁽²⁰⁰⁵⁾

MINORITY FELLOWSHIP PROGRAM AND TRIBAL OUTREACH

Mr. Udall: Dr. Cline, once again you have targeted the Minority Fellowship Training Program for elimination. Not only is there a shortage of mental health and substance abuse professionals, but there is even greater shortage of ethnic minority mental health and substance abuse professionals. The Minority Fellowship Training program has proven to be cost-effective in training and retaining professionals in the public sector. Please explain to me, again, why this program has been eliminated in your budget.

Dr. Cline: The goal of the Minority Fellowship Program is to place practitioners in clinical settings; however, only 20 percent of nursing program participants end up working in clinical care settings, only 15 percent of psychiatry participants move on to a primary clinical work setting, and only 1 percent of social work participants move on to a clinical setting. The goals of this program are better addressed through HRSA programs. The FY 2009 President's Budget includes \$121 million for the recruitment and retention of clinicians through the National Health Service Corps, which places clinicians including behavioral health professionals in communities of greatest need such as underserved racial/ethnic minority communities.

Mr. Udall: Dr. Cline, you may be aware that Congressman Honda and I inserted report language into the FY08 Labor/H bill directing SAMHSA to submit a report to Congress detailing your outreach efforts to Tribal Organizations, the current participation rates of eligible Tribal Organizations, the current participation rates of eligible Tribal Organizations, and barriers to access facing Tribal Organizations. I note that in the justification, you provided some preliminary information in response. Thank you very much for that. I also noted that none of the grantees were New Mexico tribes. I was wondering what steps SAMHSA takes to notify tribes of grant availability? What types of outreach do you do? How can we help get the word out about these opportunities?

Dr. Cline: SAMHSA's outreach efforts to Tribal Organizations are extensive and include providing training and technical assistance; formal and informal consultation; direct site visits to SAMHSA grantees; and hosting/attending Tribe-initiated meetings.

After consulting with Tribes and tribal organizations, I signed a detailed Tribal Consultation Policy in March 2007. That Policy requires the establishment of a SAMHSA Tribal Technical Advisory Committee comprised of elected tribal officials from the various regions in Indian Country. This committee met for the first time in February, 2008. In 2007, SAMHSA Executive Leadership also fully participated in the HHS Tribal Budget Consultation and seven HHS sponsored Regional Tribal Consultation sessions throughout Indian Country. In 2008, SAMHSA participated in the national HHS Tribal Budget Consultation and Regional Consultation sessions. During these sessions, SAMHSA leadership share information about existing and planned program efforts and engage in dialogue about appropriate ways to include and involve Tribal Organizations.

Based upon ongoing requests from Tribal leaders, in 2006 and 2007, SAMHSA actively participated in a Federal inter-agency effort to improve tribal capacity and infrastructure through government-to-government consultation, and training and technical assistance to tribal communities. In 2006 and 2007, SAMHSA, Indian Health Services, Office of Minority Health, (*through the US Department of Health and Human Services*) joined with the Office of Justice Programs (*US Department of Justice*); Bureau of Indian Affairs (*US Department of the Interior*); and the Office of Native American Programs (*US Department of Housing and Urban Development*) to provide four training sessions throughout Indian Country.

Building upon the positive reception for the federal inter-agency “Tribal Justice and Safety Government-to-Government Consultation, Training and Technical Assistance” sessions in 2006-2007, SAMHSA joined to provide three additional trainings on tribal priorities related to public health and public safety for families and communities. SAMHSA workshops at the first session of the 2007-2008 series held on the Santa Ana Pueblo in New Mexico focused on fiscal year 2008 grant application solicitations and included the following topics:

- Drug-Free Community Support Grants
- Grants Administration/Financial Management
- HIV/AIDS Prevention Grants
- Screening, Brief Intervention, Referral & Treatment (SBIRT) Program Grants
- Strategic Prevention Framework Grants
- Targeted Capacity Expansion Grants
- Tips For Successful Grant Writing
- Tribal Drug Courts
- Weaving the Fabric of Community Using Various Federal Funding Sources
- Suicide Prevention Funding Opportunities

SAMHSA will continue to utilize this federal inter-agency model to deliver capacity building training and workshops to Tribes and tribal organizations serving AI/AN communities including those serving urban AI/AN populations.

CEREBRAL CAVERNOUS MALFORMATIONS

Mr. Udall: Dr. Zerhouni, you may be familiar with a disease called Cerebral Cavernous Malformations (CCM), or cavernous angiomas. In the general population, 1 in approximately 200 people has a cavernous angioma. However, there is a hereditary form of the illness. In New Mexico a genetic mutation, named the Common Hispanic Mutation, has been traced back to the original Spanish settlers of the 1580's and has now spread down and across at least 17 generations. My state has the highest population density of this illness in the world, and the population is growing quickly. I have been working with some of the experts in New Mexico on this, but I understand that the most productive research program, located at Duke University, just had their most recent grant proposal denied by NIH. This unfortunately will effectively shut them down. My understanding is that the grant application received a score that was very strong, the third highest score in the Primary Investigator's 15 years of research, but was not high enough. I raise this today to bring it to your attention and to encourage you and NINDS to determine whether CCM research is being funded in proportion to its prevalence and national health impact. This is a very important issue for my state, and given its prevalence elsewhere, for the rest of the country.

Dr. Zerhouni: Mutations in three genes have been found to cause cerebral cavernous malformations (CCM), a cluster of weak or leaky small blood vessels (vasculature) in the brain. NINDS currently funds research on understanding the role of these genes and the molecular mechanisms which underlie CCM. Funded projects are aimed at understanding how the balance between cell proliferation and cell death contribute to the development of these vascular abnormalities, identifying other molecules that interact with the causative genes, and pursuing the hypothesis that an immune response is involved in the formation of CCMs. NINDS also funds research on other types of malformations that occur in the brain, including arteriovenous malformations (AVMs). Research into characterizing AVMs and identifying the best treatment approaches may help inform our understanding and treatment of other brain vascular malformations such as CCM. Earlier this month, NINDS sponsored a workshop on Biology of Vascular Malformations of the Brain, which involved organizations such as the Angioma Alliance, a voluntary health organization focused on CCM, and was attended by leading international experts in the field, including those who study CCM.

While I cannot comment on the status or outcome of a specific grant, I want to assure you that all grants submitted to NIH receive a fair and unbiased review through the NIH dual peer review process. The first level of review is carried out by a Scientific Review Group (SRG) composed primarily of non-federal scientists who have expertise in relevant scientific disciplines and current research areas. The second level of review is performed by Institute and Center (IC) National Advisory Councils or Boards. Councils are composed of both scientific and lay members chosen for their expertise, interest, or activity in matters related to health and disease. Only applications that are favorably recommended by both the SRG and the Advisory Council may be recommended for funding.

AMERICAN INDIAN/ALASKA NATIVE

Mr. Honda: In the 2008 Omnibus appropriations act, Rep. Udall and I inserted report language directing SAMHSA to study mental health services funding outreach to eligible tribal organizations. Thank you for providing us with a list of the programs and funding that you gave to tribes over the past two years and I look forward to receiving your more comprehensive report later this year.

- I noticed that the funding in 2006 and 2007 totaled about \$10 million and \$15.7 million respectively, across three different grant programs. I would like to clarify that the intent of the report language was not to shrink the federal dedication to tribal mental health and substance abuse services but to expand the funding available to those organizations and I hope you can confirm your understanding of the funding set aside in the report language.

Dr. Cline: SAMHSA's overall support for American Indians and Alaska Natives (AI/AN) in FY 2006 and FY 2007 was \$37.6 million and \$56.4 million, respectively within targeted programs, the block and formula grants, and other project grants. In FY 2008, approximately \$52 million will support existing projects. These activities include Circles of Care, Native Aspirations, Garrett Lee Smith Youth Suicide Prevention, the Strategic Prevention Framework State Incentive Grant program, Access to Recovery, Screening, Brief Intervention, Referral and Treatment, Targeted Capacity Expansion for AI/AN Communities, as well as funding to the American Indian Consortium and Substance Abuse Prevention and Treatment Block Grant funding to the Red Lake Band of Chippewa Indians of Minnesota. In addition, Tribal organizations are eligible to apply for new programs in FY 2008 such as Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) and the Sober Truth on Preventing Underage Drinking program.

In August 2005, SAMHSA initiated a new policy for FY 2006 and beyond geared toward expanding tribal eligibility to more grant programs which resulted in the awarding of grants to 12 tribal service organizations across the country. In FY 2007, 19 tribal service organizations received grants. Total funding to tribal organizations in FY 2008 will be the result not only of specially-focused program efforts, but also successful competition by tribal organizations for new funding opportunities in a variety of SAMHSA programs.

The FY 2009 Budget includes funding for Native Aspirations, an innovative training and technical assistance project that helps Tribal communities mobilize existing social and educational resources to develop and implement comprehensive, collaborative community-based prevention plans focused on reducing violence, bullying, and suicide among American Indian/Alaska Native youth. Additionally, SAMHSA has a substance abuse treatment Targeted Capacity Expansion for AI/AN Communities which helps Tribal organization expand or enhance their ability to provide comprehensive and integrated responses to substance abuse issues.

SAMHSA has also partnered with several other agencies within HHS to co-sponsor the Indian Country Meth Initiative. This program is designed to provide technical assistance to Tribes and Tribal organizations to assist them in addressing methamphetamine use in Native communities.

VIRAL HEPATITIS

Mr. Honda: As you are no doubt aware, there was a recent health scandal at a Las Vegas clinic involving faulty injection practices. At this point we know that 6 people are infected with Viral Hepatitis and there are nearly 40,000 others who have to be monitored and educated about their possible exposure to that and other blood borne diseases.

There is no chronic viral hepatitis registry established even though CDC estimates that about 4 million people in the country is living with chronic hepatitis B or C. Acute infection rates of Hepatitis B have gone down but chronic cases continue to rise for various reasons. Isn't it time the CDC puts more resources in the area of tracking chronic hepatitis infection given the cost imposed on our country by B & C?

Dr. Gerberding: Hepatitis B virus infection is a common blood-borne condition which can lead to cirrhosis and liver cancer, a leading cause of death in the U.S. Despite the availability of an effective vaccine, about 46,000 Americans are infected with hepatitis B each year. CDC has included \$17.5 million in its budget request for viral hepatitis activities, to address hepatitis A, B and C. These funds support epidemiology and surveillance, education and training, and laboratory research activities. In addition, CDC allocates some emerging infectious disease funding to help support viral hepatitis surveillance. In 2007, CDC received a total of \$4.3 million for this effort. CDC plans to spend about \$3.25 million in EI funding for viral hepatitis in 2008.

IMPROVING QUALITY OF HEALTH CARE

Mr. Honda: Dr. Clancy, AHRQ is making some significant contributions in improving the quality of health care that Americans receive. However, our health care system is experiencing rising costs, a persistence of medical errors and other patient safety problems, and issues of substandard care. How do investments in AHRQ make a difference right now?

Dr. Clancy: AHRQ has made a number of key investments that are making a difference in the quality, safety, efficiency and effectiveness of health care. While our goal is to reap sustained and long-term improvements in the American health care system, we are seeing positive changes right now.

For example, AHRQ supported research at Johns Hopkins University that developed a program that instituted a simple five-step checklist designed to prevent certain hospital infections in intensive care units (ICUs) throughout Michigan. Among other things, the checklist reminds doctors to wash their hands and put on a sterile gown and gloves before putting intravenous (IV) lines into patients. As a result of taking this simple step, the rate of bloodstream infections from IV lines was reduced by two-thirds

within 3 months. In addition, the average ICU decreased its infection rate from 4 percent to zero. Over 18 months, the program saved more than 1,500 lives and nearly \$200 million. One leader in critical care medicine described these results as one of the most important developments in a generation.

Two additional examples include sustained improvements in coronary artery bypass surgery and improvements in the detection and appropriate treatment of patients with depression. In the mid-1990's AHRQ supported the Northern New England Cardiovascular Study Group at Dartmouth, a collaborative involving cardiovascular surgeons and hospitals in northern New England to identify best practices for improving care for patients undergoing surgery. The study demonstrated significant reductions in mortality; when the grant period concluded participating hospitals created a non-profit organization to continue this work, which has sustained and advanced the initial successes. The Partners in Care study, a collaboration between a research team and multiple managed care organizations, focused on improving detection and treatment of depression in primary care. In addition to significant improvements at one year, this study also demonstrated reduction in disparities in care – results that have persisted for more than five years and resulted in increased employment of depressed patients.

Since 2004, AHRQ has invested \$199 million in grants and contracts in 48 States to support and stimulate investment in health IT, especially in rural and underserved areas. For example, with AHRQ support, Arizona is advancing an initiative for improved health information technology and health information exchange. With this initiative, the Arizona Government Information Technology Agency seeks to improve the quality of patient care while reducing health care costs. State officials estimate that as much as 10 percent of health care costs each year could be saved with successful health information exchange. In another example, we have funded a \$1.1 million grant to the University of California San Francisco to test the impact of the automated telephone self-management support system that helps patients manage their own diabetes.

AHRQ's comparative effectiveness program, which was authorized under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, conducts and supports research with a focus on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. AHRQ has released 14 comparative effectiveness reviews, ranging from diagnostic evaluation of technologies for abnormal breast cancer screening to comparative effectiveness of drugs for depression to treatments for prostate cancer.

We are beginning to see an impact from AHRQ's comparative effectiveness research. It is used by a variety of groups who make decisions about health care. For example, Consumer Reports Best Buy Drugs, a public education project of Consumers Union, uses these findings to help health care professionals and patients determine which drugs and other medical treatments work best for certain health conditions. The National Business Group on Health uses this research to provide employers and their employees' best available evidence for designing benefits and making treatment choices.

NATIONAL STRATEGY ON PANDEMIC INFLUENZA

Mr. Walsh: One of the key parts of the National Strategy on Pandemic Influenza (NSPI) is that in addition to federal stockpiles of key medicines and supplies, we also need states to act to establish their own stockpiles.

For the stockpile of antivirals in particular, the national plan calls for enough to treat 25% of the population and to reach that goal, states have to act.

It is my understanding that to date, the federal government has purchased the 50 million courses of treatment as recommended under the NSPI, while the states have stockpiled only approximately 19 million of the 31 million courses of antivirals called for in the NSPI.

Some states have completed their stockpiles, some states are partially done and others have yet to act.

- What can we do to make sure all states act? Is there a deadline by which states must order their antiviral allocation before they risk losing access to the federal subsidy?
- If even a couple of states refuse to act in advance of a pandemic, the U.S. will never reach its national goal of stockpiling enough antivirals for 25 percent of the population. How will this shortfall be addressed?
- Is there funding in the 2009 budget to address the shortfall?
- Congress has already appropriated funds for the state purchases, and HHS has set them aside for this purpose. If the states don't act, how would those funds be used?
- What will be the consequences during a pandemic for states that have failed to stockpile antivirals? Will they be at a disadvantage to states that have stockpiled antivirals?
- Also, the original pandemic plan, drafted in 2004, recommended that we stockpile enough antivirals to treat 25 percent of the population. Four years later, do you still believe that is a sufficient amount or would you recommend stockpiling more for prophylaxis (meaning to prevent the virus from spreading as opposed to using antivirals for treatment only)?

Dr. Gerberding: The national pandemic influenza antiviral drug stockpiling goal is 81 million treatment courses with 6 million designated for early containment usage at pandemic onset and 75 million treatment courses for treatment of infected persons. As of Feb. 22, 2008, forty-five States, territories, and the District of Columbia have procured 21.7 million treatment courses of influenza antiviral drugs. Only six States do not intend to use their Federal subsidy allocation. The present deadline for States to utilize their Federal subsidies to purchase antivirals for pandemic stockpiles is July 31, 2008. By the end of March 2008, HHS will complete communications with those States that have not fully utilized their Federal subsidy allocations to ascertain the status of their commitments to complete this pandemic preparedness measure.

Subsequently HHS will appraise the State antiviral drug stockpile program and determine the next steps including reapportionment of Federal subsidies to States.

Major issues preventing some States from purchasing influenza antivirals were the expiration dating and shelf life extension of these products. Recently the FDA accepted the product claim by Roche for Tamiflu® to increase expiration dating from five to seven years; the new expiration dating would apply to both Federal and State pandemic stockpiles of this product. Coordination of the manufacturer, FDA, States, and third party companies is underway for the relabeling of the product already in State stockpiles. Lastly, the issue of being able to use the pandemic antiviral stockpiles in States for severe seasonal influenza outbreaks has been a limiting factor. New Mexico has solved this problem by purchasing the antiviral directly from the manufacturer at greater than the Federal contract price but considerably less than retail prices. Their stockpile has the added flexibility to address both seasonal and pandemic influenza outbreaks and for treatment and post-exposure prophylactic usage.

Currently HHS has obligated \$91 million of the \$170 million appropriated for Federal subsidies to State antiviral drug stockpiling (an additional \$27 million will be obligated later this month). HHS will obligate these funds over the next six months as orders by States using the Federal antiviral drug contracts emerge. The HHS FY 2009 pandemic influenza budget request did not include additional funding of the State antiviral drug stockpiling program. Decisions on remaining funds, if any, will be part of the next steps process described above.

At the onset of an influenza pandemic, States will receive *pro rata* allotments of influenza antiviral drugs from the Strategic National Stockpile. The Federal stockpiled antiviral drugs will comprise 59% of the total number of antiviral drug treatment courses recommended for each State; the remaining 41% is the responsibility of each State, for which 23 States have completed to date. States have until July 31, 2008 to utilize their full allotment of Federal subsidies and Federal contracts with antiviral drug manufacturers to procure these drugs at significant savings. Afterwards, States may continue to purchase these antiviral drugs for their pandemic antiviral drug stockpiles using their own contracts with the manufacturers.

Secretary Leavitt has stated on numerous occasions that pandemic preparedness is a shared responsibility that the Federal government cannot shoulder the entire burden, and that States, local government, businesses and families must first rely on themselves to become fully prepared.

FLU VACCINE

Dr. Weldon: Dr. Gerberding, we understand that this year's flu vaccine did not perform nearly as well as expected. We understand that new technologies are available that would be predictive of which influenza strains to include in the vaccine formulation. These technologies are centered around reliable, high-throughput in vitro methods for evaluating human immune response. Considering that thousands of Americans suffered from flu-like symptoms this year due to the mismatch in influenza strains, the Committee would be interested in how the CDC is engaging with these technologies to prevent this from happening next year?

Dr. Gerberding: Early each year, potential vaccine strains are evaluated to determine those most likely to provide protection against anticipated circulating influenza viruses in the coming influenza season. The selected vaccine strains must demonstrate good capability to grow in eggs, since the vast majority of influenza vaccines manufactured in the United States use eggs to make the viruses used in the vaccines. The manufacturing process for influenza vaccines requires sufficient time to identify H3N2 influenza viruses that grow well in eggs (H3N2 unfortunately is one influenza virus that does not grow as well as other influenza viruses in eggs) and to then grow the viruses in eggs. Therefore, vaccine strains must be chosen many months before the influenza season begins.

The delays in identifying suitable drifted H3N2 strains for updating the composition of the most common formulation of influenza vaccine, trivalent inactivated vaccine (TIV), are due to the difficulty of growing influenza viruses in chicken embryos. Chicken embryos are the only FDA-approved substrate for manufacturing TIV in the United States. Less than 1 percent of the clinical specimens inoculated into eggs yield a virus isolate; many of which do not have the desired properties.

CDC and other agencies in the Department of Health and Human Services maintain a continuous review of the multiple steps for selecting vaccine candidates and are evaluating various approaches to decrease the time for identifying candidates and for improving the selection of candidates with highest levels of protection. We are interested and engaged in evaluating new and experimental approaches to in vitro methods for evaluating human immune response. While some of these methods may show promise in elucidating immune responses more rapidly, predictive high throughput systems do not substitute for egg isolation of H3N2 viruses, which remains a requirement for vaccine strains and continues to be a critical control point that can delay vaccine manufacturing.

TUESDAY, FEBRUARY 26, 2008.

**HEARING ON THE PRESIDENT'S EDUCATION BUDGET
FOR 2009**

SECRETARY OF EDUCATION

WITNESSES

HON. MARGARET SPELLINGS, SECRETARY OF EDUCATION
THOMAS P. SKELLY, DIRECTOR, BUDGET SERVICE

CHAIRMAN'S OPENING REMARKS

Mr. OBEY. The Committee will come to order.

This morning, we will be hearing from the Secretary of Education who will be outlining the President's requested budget for education for the coming fiscal year and, undoubtedly, we will hear a lot of discussion about the cost of meeting our obligations in the area of education. This afternoon, we will hear from a second panel which will focus on the cost of not providing our obligations to education.

Madam Secretary, we welcome you here. Unless some future President has some plans for you of which I am not aware, this is your last appearance before the Subcommittee on a regular bill.

Secretary SPELLINGS. I am assuming that it is. [Laughter.]

Mr. OBEY. Let me simply say this. I think it is fair to say we have had a good number of disagreements with the Administration on education policy as well as education budgeting, but nonetheless I simply want to say that you are obviously a person of ability and dedication. I appreciate the service that you have given to the country, and I hope that we can make this coming year a productive one. I think we have a problem, and I hope we can overcome it.

If we take a look at the President's budget from last year, across the board on domestic funding, he essentially, with a few exceptions here and there, he essentially presented a budget to us which was a freeze. This year, what he has done is to send a budget to us on the domestic side which cuts about \$18 billion out of accounts that the Congress just approved a few months ago.

The bill that was passed last year was an extremely tight bill which caused consternation, I think it is safe to say, on both sides of the aisle. In fact, we had 51 Republicans voting with Democrats to override the President's veto on the Labor-H Bill because the President's budget was seen as being so tight.

This year, the situation is considerably more grim because it isn't just a freeze. It represents a determination and makes some very deep cuts in a lot of programs in and outside of education.

We are going to have a choice to make this year, and we are essentially, in the Congress and in this Committee, going to have two

options. The first option is to try to reach a compromise with the Administration on its budget recommendations. That would be my preferred route.

The kind of politics I believe in practicing dictates that we first define our differences and we can have at each other on those differences, and then we are supposed to try to resolve those differences. It is hard to do if one side or the other is stuck in a my way or no way approach to things.

So I think we have two choices. We can try to work with the Administration and hope that the President will show some flexibility in both his policy prescriptions and his numbers. If he does, fine. We can find agreement, and we can try to pass the bill through both houses.

If he chooses, as he did last year, to simply say, sorry, not going to compromise on the numbers, then there is very little incentive for this Committee to do anything except say, well, the President has dealt himself out of the game and we will simply have to wait for a new President who is more flexible in order to deal with the problems.

Those are the two choices open to us, and it is going to be largely up to the Administration which path we wind up following. I hope it is the former because I think there is important work that we can still do if we work together. Example: No Child Left Behind, it has come under a lot of criticism.

FUNDING LEVEL FOR NO CHILD LEFT BEHIND

I voted for it. I voted for it for two reasons: number one, because I thought that we needed to try to focus on strengthening standards for all kids and, secondly, because I thought it was the President's first domestic initiative out of the box and because of that I thought he was entitled to the benefit of the doubt, but it was also based on my assumption we would stick reasonably closely to the budget numbers that were provided in that legislation.

Now I have been around here a long time. I don't expect every authorization bill to be fully funded. In fact, I would not support that in many instances. But I do think that we had a right to expect that if we were going to require all of the things that were required of State and local people under that legislation, that we stick fairly closely to the implied commitment on the financial front that was represented by that bill.

For the first year the President did that, but then in succeeding years the increases that he asked for, for education, each year were about half of the increase of the previous year. As a result, we are left far behind in terms of our financial commitments.

So I would hope that we can see considerable flexibility on the President's part, and if we can, we ought to be able to reach reasonable agreement. If we can't, then it turns this year into a waste. We have a choice as to whether this year is going to be eight months of wasted time or eight months of trying to tie up a lot of loose ends and getting some constructive things done.

I think which of those paths the Congress has to take is going to be largely determined by the other end of the avenue, and I hope that we are met with a willingness to compromise that we did not see last year. Last year, when I talked to Budget Director Nussle

and told him we were looking for ways to compromise, he told me that he could find nobody in the White House who had the slightest interest in compromising. That is not going to be a way to use our time very productively this year.

So let me simply stop at that point and call on Mr. Walsh for his comments before I invite you to make your statement.

Mr. Walsh.

EDUCATED WORKFORCE AND LONG-TERM COMPETITIVENESS

Mr. WALSH. Thank you, Mr. Chairman.

Madam Secretary, welcome. I would like to echo the comments of the Chairman regarding your abilities and your character. I think you have done a great job as Secretary, and I appreciate the effort that you have put into it and the thoughtful approach that you have taken.

I think we all agree that a well-educated workforce is critical to our long-term competitiveness as a Nation and that quality education must begin early in the home and in our elementary schools.

The budget you have sent us makes choices, some of which I think are good choices, others I will question, but nonetheless it makes choices and sets priorities, and I commend you for that.

I will tell you I agree with the choice to provide yet another increase for elementary and secondary education. While the Federal Government contributes less than 10 percent of funding for education in this country, I think the investment we make at the Federal level is very important, particularly for schools that serve low-income children. I subscribe, though, to the view that public education should be the purview of the local communities, supported by local taxes as best they can.

I am also very pleased to see that you have requested a significant increase for special education programs. I would like to ask you a little bit more about that as we go forward. But, as you know, these are critical funds that school districts use to help kids with learning disabilities and that has been a priority of this Subcommittee historically.

So I look forward to your testimony, and I yield back, Mr. Chairman.

OPENING STATEMENT OF SECRETARY SPELLINGS

Mr. OBEY. Madam Secretary, why don't you summarize your statement, and we will put your full statement in the record?

Secretary SPELLINGS. Thank you, Mr. Chairman, and thank you, members. I, too, am pleased to be back visiting before you.

FEDERAL ROLE IN EDUCATION

As you said, Mr. Walsh, all of us agree that in today's competitive world, developing human capital is a top priority. We also know that we have limited resources to invest and that our primary role at the Federal level has always been to serve our neediest students, such as those from low-income families, those with disabilities and those learning English as a second language. Accordingly, we must ensure that taxpayer dollars are allocated in the most effective and efficient ways.

PRIORITY INVESTMENTS IN FEDERAL EDUCATION BUDGET

Since becoming Secretary, I have traveled the country, discussing No Child Left Behind and its implementation and gaining insights on ways to strengthen and improve this law. Everywhere I go, I have been talking with educators and policymakers who are deservedly proud that student achievement is rising under No Child Left Behind and that gaps between poor and minority students are closing.

In addition, they all share common challenges. First, educators need proven strategies to strengthen instruction, especially in reading. Second, they need resources to help students and schools improve. Finally, they need help to make college more accessible and affordable for students of every background and income level.

These are the priority investments in the President's budget request.

READING FIRST

First, instruction: One thing we know for sure is that we will not be successful in education until every child can read. Reading opens the door to every other subject and is a critical foundation for all learning. That is why I am pleased that the President's budget restores funding for the Reading First program to \$1 billion, the level you supported for 5 years.

In response to concerns raised about the Department's initial management of the Reading First program, I adopted every recommendation my inspector general issued in September, 2006. Shortly thereafter, I put in place new leadership to oversee this program and enhanced guidance on how it should be administered. I implemented a new system to strengthen the peer review process and took further steps to prevent conflicts of interest.

Reading First builds on more than 20 years of independent research funded by this Congress and conducted by the National Institutes of Health. If ever a program was rooted in science and research, this is it.

The 60 percent cut to the 2008 appropriation for Reading First is hurting our elementary schools. It is one of the top concerns I have heard in every State I visit, and I urge you to support the President's request to restore funding so that over one and a half million students can once again benefit from this program.

STUDENT, TEACHER AND SCHOOL IMPROVEMENT PROGRAMS

Second, struggling students and schools: I am sure you have heard concerns, like I have, raised that No Child Left Behind labels too many schools as failing. In actuality, no part of this law ever uses the word, failing.

What No Child Left Behind has done is to help identify about 2,300 out of 100,000 schools nationwide that have missed annual targets for 5 or more years. The fact that just 2 percent of schools are chronic under-performers does not seem overstated, particularly when we consider that only half our minority students graduate from high school on time.

To help educators improve struggling schools, our budget provides nearly \$5 billion in school improvement grants. It raises Title I funding for high-poverty schools by \$406 million.

It more than doubles the size of the Teacher Incentive Fund by providing \$2 billion to attract our most effective teachers to work in our neediest schools and reward them for results, and it provides additional funds for students who need extra help, including an increase of nearly \$5 billion for students with disabilities and an increase of \$3 billion for those with limited English skills.

PELL GRANTS FOR KIDS PROGRAM

In addition, as we triage low-performing schools, we must also offer lifelines for families. That is why the President called for a new Pell Grants for Kids program in his State of the Union address. This program offers \$300 million in scholarships to enable poor students in struggling schools to transfer to a new school of their choice. This program begins to answer one of parents' most vexing questions: If I have given my public school every chance to meet my child's needs but it hasn't, what options do I now have?

ACCESSIBLE AND AFFORDABLE HIGHER EDUCATION

Third, higher education: All of us know that making a college education more affordable is a real concern for students and families. So I am pleased that our budget raises the Pell Grant award to \$4,800 this year, the largest amount ever.

I am proud that this issue has strong bipartisan consensus, but as we work to reauthorize the Higher Education Act, we must remember that more money is not the only answer to questions of access and affordability. We must also curb the dramatic rise of tuition costs and streamline the financial aid process.

ELIMINATIONS BASED ON OMB PART PROCESS

Finally, focusing on these priorities has required that we make tough choices just like you must do every year. And, accordingly, using the Office of Management and Budget's PART process, we have redirected funding away from programs that are ineffective, duplicative and small in scale, and we have eliminated earmarks in keeping with the President's government-wide call.

In closing, especially because as you said, Mr. Chairman, this may be my last opportunity to appear before you, I want to thank all of you for your commitment to improving our schools. Mr. Chairman, by choosing to lead this Subcommittee in addition to the full Committee, you have shown dedication that benefits all of us under your jurisdiction.

In my experience, education has been an issue that unites people of every race and background from both sides of the aisle, especially as our global economy places greater demands on our schools. Not only are many of us parents, but we also realize that even as administrations come and go, schools remain open and educators and policy makers all over this country and in this body remain committed to extending opportunity to every corner of our Nation.

I look forward to working with you to support them in that essential work.

Thank you, Mr. Chairman. I would be happy to answer your questions.

[The prepared statement and biography of Secretary of Education, Margaret Spellings follow:]

DEPARTMENT OF EDUCATION

Statement by

**Margaret Spellings
U.S. Secretary of Education**

on the

Fiscal Year 2009 Budget Request

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to testify on President Bush's fiscal year 2009 budget for the Department of Education, and to talk with you about how we hope to keep moving forward on education during the President's final year in office.

The President's budget makes the difficult choices needed to deal with a number of important challenges facing the Nation, such as strengthening the economy, keeping America safe, and ensuring that we get to a balanced budget by 2012.

Despite this tight budget, the President is again making education a priority. The fiscal year 2009 discretionary request for the Department of Education is \$59.2 billion, about the same as the 2008 level. Within that total, we are providing significant increases in several areas, both by reducing funding for lower priorities and by proposing the elimination of 47 programs totaling almost \$3.3 billion. Most of these programs are small (27 are below \$25 million); have a limited impact; duplicate larger, more flexible authorities; or have failed to demonstrate positive results.

This is President Bush's final budget for education, and while history shows that increased spending doesn't always equal improved student results, this Administration has generously supported key priorities that we believe are improving student achievement. For example, under the President's 2009 request, funding for Title I Grants to Local Educational Agencies—the cornerstone of No Child Left Behind—would be up by \$5.5 billion, or 63 percent, since 2001. Funding for IDEA, Part B, Special Education Grants to States would be up by almost \$5 billion, or 78 percent. And Pell Grant funding would reach \$18.9 billion, an astounding increase of \$10.1 billion, or 116 percent, since the President first took office.

Overall, we have a discretionary request for education that is \$17 billion higher than in 2001, an increase of 40 percent that, given the many competing demands placed on the Federal budget, clearly demonstrates this President's commitment to America's school children.

NO CHILD LEFT BEHIND

Before I turn to the highlights of our 2009 request, I want to talk a little about the progress we have made under No Child Left Behind (NCLB) over the past six years. I truly believe that NCLB has changed the education game in this Nation and laid a solid foundation for continued progress in raising student achievement and preparing all Americans for either postsecondary education or the competitive workforce.

All States now have strong educational accountability systems based on annual assessments in reading and mathematics, provide detailed information and data on the performance of all students, hold schools accountable for the achievement of not just the majority of their students but also for minority subgroups, and make available public school choice and supplemental educational services (SES) options for students in low-performing schools.

The experience of successfully implementing NCLB also has shown us where we need to go in the future. We have a comprehensive reauthorization proposal that provides a detailed roadmap for improving and expanding the impact of NCLB, but I think there is already a strong consensus around several needed changes. These improvements can be made through administrative and regulatory actions right away, while we continue to work with Congress on a full reauthorization package.

For example, I have already moved to expand eligibility for participation in our Growth Model Pilot program to all States. Other areas that we are looking at include improving graduation rate calculations, clarifying school improvement requirements, and encouraging better monitoring of SES providers. In each of these areas, the Department is drawing on feedback from States, school districts, and schools about how to improve implementation of the current law to help ensure that all students reach proficiency in reading and math by 2014.

Our number one goal this year is to complete the reauthorization of NCLB, and I stand ready to work with Congress to deliver a strong bill to the President's desk for his signature. But whether Congress acts on reauthorization or not, we need to keep moving forward to make the promise of No Child Left Behind a reality.

NCLB REMAINS A KEY BUDGET PRIORITY

Returning to the 2009 President's budget for education, No Child Left Behind has obviously been a key budget priority for the past seven years, and that's true this year as well. Under the 2009 request, total NCLB funding would be up almost \$7.2 billion, or 41 percent, since 2001. This includes a \$14.3 billion request for Title I Grants to LEAs, an increase of \$406 million over 2008, and \$491.3 million for Title I School Improvement Grants. School improvement has become a key emphasis in the past few years, both for the Administration and for the Congress. Together we have more than quintupled funding to help States and school districts turn around low-performing schools, from \$207 million in 2002 to an estimated \$1.1 billion in 2009.

Another major goal for 2009 is restoring funding for Reading First State Grants to \$1 billion, an increase of \$607 million over the 2008 level for this effort to deliver on the NCLB promise of applying scientifically based research to key challenges in education. We know the Department made mistakes in administering Reading First, but it just doesn't make sense to punish the more than 1.6 million students across the Nation that are benefiting from Reading First. The Department has worked hard to address previous problems and improve the management of Reading First, and I hope this Committee will agree to restore funding for what is arguably one of the most effective Federal education programs in history.

The President's American Competitiveness Initiative also supports key NCLB goals, such as using research-based instruction, increasing academic rigor in our high schools, and attracting talented teachers where they are most needed. The 2009 request would provide \$175 million, an increase of \$131.5 million over the 2008 level, for ACI proposals aimed at improving math and science instruction in K-12 schools. This total includes \$95 million for the newly authorized Math Now program to implement research-based practices in math instruction, including those that will be recommended by the National Math Panel later this year. The ACI request also would provide a \$26.5 million increase for Advanced Placement and International Baccalaureate programs, as well as \$10 million for our Adjunct Teacher Corps proposal, which would encourage talented professionals with subject-matter expertise in mathematics and the sciences to teach such courses in our high schools.

One additional proposal that I want to mention is our \$200 million request for the Teacher Incentive Fund. This request would more than double existing support for incentives for talented teachers to teach in low-performing schools. TIF grants encourage States and school districts to reform compensation plans to reward principals and teachers who raise student achievement, close achievement gaps, and work in hard-to-staff schools. We all know the difference that a good teacher can make in a child's life, and this program helps get good teachers where we most need them.

MORE CHOICES FOR STUDENTS AND PARENTS

I mentioned earlier the strong emphasis we are putting on school improvement under No Child Left Behind. As we move closer to the target date of 2014 for reaching 100 percent proficiency, States are identifying more and more schools for improvement. In particular, the number of schools identified for fundamental restructuring reforms is growing rapidly, from roughly 1,700 schools in the 2005-06 school year to almost 4,000 schools in the current school year. Our request would make available nearly \$1.1 billion in 2009 to help turn around these schools. At the same time, we must provide immediate help for the students in these schools by increasing the availability of educational options that can improve student outcomes.

This is why a key focus of both our effort to successfully reauthorize No Child Left Behind and our 2009 budget request is increasing choices for students in low-

performing schools. For example, we are modifying our reauthorization proposal for the 21st Century Community Learning Centers program to transform it into an after-school program with a much tighter focus on improving the academic achievement of students in low-performing schools. We are asking for \$800 million in 2009 for the renamed 21st Century Learning Opportunities program, which would provide scholarships for students to choose from a wide range of providers of academically focused after-school and summer school programs. Unfortunately, the current 21st Century program has failed to demonstrate achievement gains by participants since 2004.

We also are proposing a new \$300 million Pell Grants for Kids scholarship program, which would allow low-income students attending schools in restructuring, or that have high dropout rates, to transfer to a local private school or an out-of-district public school. This new program is based on the highly effective and highly popular Pell Grant program, which has enabled millions of low-income students to attend the public and private institution of higher education of their choice. Our most disadvantaged elementary and secondary school students deserve the same opportunities college students have enjoyed for decades. While we believe that students deserve the opportunity to attend a wide variety of schools, including private schools, I was pleased to see Congressman Emanuel introduce a similarly named version of this proposal arguing that students in these persistently underperforming schools need immediate options. I look forward to working with Congress to find the best way to address the reality that in many school districts, particularly in urban areas, there are too few public school options available to students in chronically low-performing schools.

PELL GRANTS

Finally, our 2009 request keeps faith with the remarkable progress we have made in expanding the reach and value of the postsecondary Pell Grants program over the past several years. As I said earlier, the 2009 request for Pell Grants is \$18.9 billion in combined discretionary and mandatory funds, which results in a total increase of \$10.1 billion, or 116 percent, over the past 8 years. The 2009 request includes a discretionary increase of \$2.6 billion for Pell Grants.

This request would provide Pell Grants to some 5.8 million students, an increase of 1.5 million, or 33 percent, since 2001. Moreover, while serving all those additional students, we also managed to raise the maximum award from \$3,750 to \$4,800, an increase of 28 percent. This is the highest maximum award ever, and our request would keep the maximum award on its path toward \$5,400 in 2012. In addition, the average Pell Grant would exceed \$3,000 for the first time under our 2009 request.

The significant resources for Pell Grants in our 2009 request will help ensure that students from low-income families who work hard and graduate from high school have the resources they need to enter and complete a college education.

CONCLUSION

I want to conclude by thanking the Members of the Committee for your support over the past several years. This is likely to be my last appearance before the Committee, and I am grateful for the progress that we have been able to make together on behalf of American students of all ages. I know we have not always agreed on the particulars, but I have never doubted that we share the same goal of creating the world-class education system that our citizens both need and deserve. I look forward to working with you this year, and I will be happy to take any questions you may have.

Margaret Spellings
U.S. Secretary of Education

Biography

Margaret Spellings is the U.S. Secretary of Education. As the first mother of school-aged children to serve as Education Secretary, Spellings has a special appreciation for the hopes and concerns of American families.

Secretary Spellings is working to ensure that every young American has the knowledge and skills to succeed in the 21st century. She has partnered with states to implement and enforce the *No Child Left Behind Act*, which commits our schools to bringing all students up to grade level or better in reading and math by 2014. The law has led to rising test scores and shrinking achievement gaps in states across the country.

Secretary Spellings has been a leader in reform to make education more innovative and responsive. She supported teachers with new financial incentives for gains in student achievement and parents with new educational choices and options. She announced new rules to ensure that students with disabilities and English language learners are educated to the highest standards. She also proposed a landmark Plan for Higher Education that would improve accessibility, affordability and accountability.

Secretary Spellings believes we must not retreat from the world in the face of increased competition. She is leading the effort to pass President Bush's American Competitiveness Initiative, which would strengthen math and science instruction and encourage high schools to offer more rigorous and advanced coursework. She worked to implement Academic Competitiveness and National SMART grants, which are providing millions of dollars to low-income students who major in math, science, or critical foreign languages.

Prior to her tenure as Education Secretary, Spellings served as Assistant to the President for Domestic Policy, where she helped create the *No Child Left Behind Act* and crafted policies on education, immigration, health care, labor, transportation, justice, housing, and other elements of the President's domestic agenda. Previously, Spellings worked for six years as Senior Advisor to Governor George W. Bush with responsibility for developing and implementing the Governor's education reforms and policies. From the White House and the Statehouse to the school board and college campus, Spellings has been involved with education policy at every level.

Born in Michigan, Spellings moved with her family at a young age to Houston, Texas, where she attended public schools. She graduated from the University of Houston with a bachelor's degree in political science.

FEDERAL SHARE OF SPECIAL EDUCATION APPE

Mr. OBEY. Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

Madam Secretary, last year, we, this Subcommittee, moved money from a workforce training program, unexpended funds, into the IDEA fund. It was a fairly popular decision, tough call, but a fairly popular decision, and it was in the neighborhood of \$300 plus million. Even with the increase that was requested by the Administration, adding that to it, we only went from 17 percent of our commitment to about 17.2 percent of our commitment.

The Administration this year is requesting an additional \$337 million for Special Education State grants. It is a very substantial amount of money, and yet we are still just holding even. As you know, Congress's commitment initially in authorization was to provide 40 percent of the cost.

This is a high priority for all communities, but can you explain why we just can't ever seem to catch that goal?

Even with these substantial increases, why? Is it the cost of teaching kids with disabilities? Is it the number of kids being listed? Is it a lack of commitment on the part of Congress to meet this goal?

Secretary SPELLINGS. Well, Congressman, I think you are right.

A couple of things: Yes, average per pupil expenditure costs of educating special education students certainly have gone up as have identification and diagnoses costs of such students. We now have 13 or 14 percent of our students nationally who are diagnosed. We have gotten more sophisticated. We have gotten better at it.

And, as young babies who previously were not saved are now living and being educated and living fruitful lives, more of those kids, of course, are in our public schools. I think that is one of the reasons that we find getting that Federal share of APPE up so vexing.

SPECIAL EDUCATION AND NO CHILD LEFT BEHIND

I do think one of the things from a policy perspective that has been very useful is with No Child Left Behind, as you know, those students are subject to the accountability features there as well. It has provided us some opportunity to be much smarter about how we assess and remediate and intervene with those learners, and it has built a lot of demand to build better practice, better science and better interventions for those kids because we are holding our schools accountable.

AUTHORIZED FEDERAL SHARE OF APPE

But, again, as you rightly said, more kids, higher costs make it harder for us to continue to move the needle.

Mr. WALSH. This is such a challenge. Do we abandon this goal of providing 40 percent?

After 20 plus years, we are still not even at half of our commitment. Is there some way to get a quantum leap in how we deal with kids with learning disabilities?

We are continually criticized. The Federal Government is criticized for not providing enough resources for these kids because of

this commitment that we made. Is it still realistic to think we can cover 40 percent of the cost?

Is it not an unfunded mandate when we tell school districts to do these things?

I just think we have a very praiseworthy goal, but we never seem to attain it, and I think it bedevils us.

Secretary SPELLINGS. Yes. As you rightly observed in your opening statement, we are a 9 percent investor in education from the Federal level overall, and so that 40 percent commitment in IDEA is clearly well beyond that.

EFFECTIVENESS OF SPECIAL ED DIAGNOSIS/INTERVENTION

A couple of things I would say: One is we have gotten, I think, much more effective with respect to diagnosing and intervening and correcting special ed kids who are there because they had an undiagnosed and uncorrected reading difficulty. That is one of the things that has proven very effective about Reading First, to make sure that the kids who are diagnosed as special ed are the ones that actually ought to be there and served in that way.

Secondly, as I said, No Child Left Behind has done a great deal to build demand for better, more effective and, frankly, more efficient ways to serve those youngsters. When we had this "put the money out, hope for the best" kind of approach, I think the science around our best practices was more limited.

We are starting to see better assessments, better response to intervention, better techniques around how to meet those learners. Theoretically, as that improves, costs will modulate.

TEACHING CHILDREN WITH DISABILITIES

Mr. WALSH. Just one last thought on that and then I will yield back my time. I think one of the problems is teachers in many school districts are not prepared to teach kids with learning disabilities. Kids learn differently.

I don't know how you do that because everybody is different. Everybody has different abilities. Every child learns, well, not every child learns in a different way, but some kids learn in different ways.

Is there a way to get at the teacher aspect of this also?

Secretary SPELLINGS. Absolutely. I think, frankly, one of the pioneering parts of teacher education or of education policy has been the special ed community. They have been leaders. They are the people who first used the brain research, the reading research most effectively, and some of our best prepared teachers, frankly, come out of that sector.

I think in the general education programs, we have a lot to learn from them. Again, I think this focus on raising achievement levels of every kid to grade level and so forth has really built more demand for that, and certainly that is what our educators are calling for.

Mr. WALSH. Thank you for your indulgence, Mr. Chairman.

Mr. OBEY. Thank you.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

PROPOSED CUTS IN EDUCATION PROGRAMS

Secretary Spellings, once again in my opinion and I think the facts bear this, the Administration has proposed a budget that doesn't come near meeting the stated policy goals of improving student achievement, of meeting what was promised in No Child Left Behind or improving global competitiveness.

It recommends cuts. It eliminates programs that Congress has rejected time and time again where we know, as Chairman Obey pointed out, where there are clear differences and the Administration has continued to ignore Congress's differences on these.

EDUCATION FINANCE ISSUES IN THE STATES

School districts in Minnesota and all around the country are facing incredible financial challenges. What this means back home are levies on property tax payers, senior citizens, working poor over and over and over again, and many States, including Minnesota, are now facing a deficit.

In my school districts, there is no more fat to cut. We have all seen the facts. Forty percent of school districts across the country are cutting music, social studies, physical education and even lunch. Minnesota and other States are considering to opt out of No Child Left Behind because of the broken funding promises.

The President's budget cuts. It underfunds the very things that children need to be successful.

Your reply back in the budget is if States want to make up for these cuts in some areas, and I will use drug-free schools for an example, school districts can just take the funding from a different source. But, as I have pointed out, we have cut to the bone.

Since this budget is inadequate across the board, I want to know what the Department's suggestion is to make up for cuts in special education. It does go down.

I have read that school districts are spending more on special education than they are on general education in some cases because of rising costs, the flat funding for Title I while the number of students grows and the challenges faced by the districts increase, the cuts to the after-school programs—I already mentioned safe and drug-free schools—and the elimination of counseling and mentoring.

To make up for the lost funding, what should they do?

Do I tell them to cut teachers, cut curriculum, to continue to increase taxes on local property payers or should we tell students and families in our districts they can get by with what will be the new quality public education, underfunded, cuts, less opportunity?

Now I want to make it clear. I am for accountability, and I have worked on that as a State legislator as well as here in Congress, but it is clear to me that there is some very serious analysis that has to be done about the effects of these programs and what they are having on our schools.

COSTS AND GAINS OF EDUCATION ACCOUNTABILITY

So I have a couple of questions: How much are we spending nationally, and I mean how much are the Federal, State and local governments spending on testing for No Child Left Behind?

How many hours, individually and collectively, are we using of our students' time to take the test for No Child Left Behind?

Are we getting enough results from the expenditures of this money and this time to justify the expense for the results we are seeing?

Does the Department have any analysis of what schools are giving up when they are shifting resources to testing?

What are the effects that dwindling resources have on the long-term success of our students?

I want to move past the rhetoric. I want to bring everyone to the table. I want to put together a plan for public education that moves our country forward and prepares the next generation to be globally competitive.

I have an addendum to my prepared statements. You mention that only 2 percent of the school districts, I believe, are not making adequate yearly progress. Yet, I have submitted both in this Committee and in the Policy Committee a report from Minnesota State Auditor Jim Nobles, a nonpartisan number cruncher. He says, by 2016, Minnesota schools in general, all Minnesota schools, will not be meeting adequate yearly progress.

So I have some doubt to how you came up with the statement that you used for the 2 percent, Madam.

Thank you.

GROWTH-BASED ACCOUNTABILITY MODELS

Secretary SPELLINGS. Thank you, Congresswoman. Lots of issues to tackle there. Let me begin with the issues related to No Child Left Behind and the last point you made. In your State, there are 7 schools in restructuring. Seventy percent today make the No Child Left Behind targets.

One of the things that is going on as you all work here in the appropriations process is our look at reauthorizing No Child Left Behind under Chairman Miller's committee. One of the things that would mitigate against—I mean I assume his assumption is that the same pace of identification that we have had would continue in the future—is for us to start to look at a growth model, a value-added approach for us to look at ways to potentially be fairer in establishing accountability for our schools.

I have given waivers to nine States to start to look at that method and have recently made that opportunity available to every State nationally. So what I am trying to say is we met the need for a new approach.

Ms. MCCOLLUM. Is there money in the budget, in the President's budget for developing this new growth model for the States?

Secretary SPELLINGS. This is largely about State data systems, yes, and we have additional funds for States to develop methods, data system methods to track that progress over time. So, yes, and I will get to the specific dollar amounts with respect to that last point.

Ms. MCCOLLUM. And you had to cut something to do that, okay.

NO CHILD LEFT BEHIND TESTING COSTS

Secretary SPELLINGS. On testing, we spend about \$400 million at the Federal level on assessments. What is required under this law

is that States test one time a year in reading and math and they report that information in a disaggregated way.

To the extent that States or local school districts go beyond that and assess at benchmark points throughout the school year, that is certainly within their purview, but it is not required by No Child Left Behind.

Ms. MCCOLLUM. My question was just for the funding for No Child Left Behind, how much is it costing States and school districts to fund No Child Left Behind testing?

Secretary SPELLINGS. The full cost of assessment under No Child Left Behind is about \$400 million and is paid for as part of this Act, the full cost.

Now, as I said, to the extent that others go beyond and put additional assessments in or additional subjects, then that is certainly their prerogative, and I would have no way of knowing what those costs are.

Finally, I would just say that with respect to your issue of narrowing curricula and so forth, the Federal role as part of No Child Left Behind is around grade level achievement in reading and math, and that has been the focal point of this law because this was certainly a bipartisan agreement that those were the gateway skills necessary to be effective in science or social studies or whatever. And so, that is kind of our discreet, yet vigorous, role around issues of reading and math.

In conclusion, I would say that one of the things that you need to know—because I know we have, obviously, these perennial discussions about adequacy of resources—is that funding is up 63 percent in Title I since the President took over and there is a 41 percent increase in NCLB funding. Those are all the programs that go under the NCLB rubric. That has absolutely kept pace with increases in expenditures at the State and local level.

So, to the extent that, pardon me.

Mr. OBEY. Finish your sentence.

Secretary SPELLINGS. I was just going to say, to the extent that costs are up at the State and local level, we have certainly accommodated those increases at the Federal level as well.

Mr. OBEY. Mr. Rehberg.

Mr. REHBERG. Thank you, Mr. Chairman.

IMPACT OF BUDGET REQUEST ON NATIVE AMERICAN STUDENTS

One of the problems that I have is that while I supported No Child Left Behind and we can claim a lot of success or use it as a way of claiming success, the difficulty I see is in matching the dollars that we spend at the Federal level for the kids that are identified under No Child Left Behind as having the problems.

As I go through the President's budget again, much the same as my criticism of the last budget that the President presented to this Subcommittee, it is the cumulative effect of what it does to my Native American population. It isn't usually one tax that gets a business or one regulation. It is the cumulative effect of all the taxes and all the regulations.

When you have schools with students that are having difficulty and then the President brings in the budget once again that sorely underfunds Impact Aid, especially the construction programs, zeros

out for any increase, rural education, slight increase in IDEA, TRIO, zero percent increase, tribal colleges, cutting of \$23 million, it is the cumulative effect of all of that that we just don't see the support coming out of No Child Left Behind.

You can say it does. You can put all the platitudes on it that you want, but the tribal schools in my State and the tribal colleges in my State will tell you that this Administration doesn't get it.

So, aside from hanging on to the No Child Left Behind, how can you defend the budget that is impacting the tribal schools within the State of Montana?

Secretary SPELLINGS. Well, as I said, Congressman, the approach of the Administration has been to make a priority of programs that are large in nature and that have a lot of latitude around them: IDEA, Title I.

Mr. REHBERG. Large in nature? I thought No Child Left Behind was about the individual child.

Secretary SPELLINGS. It is.

Mr. REHBERG. Cumulatively, you are affecting those individual children by either not increasing the funding within those particular programs or cutting in the case of the tribal colleges. So I don't get it.

AUTHORIZED FEDERAL SHARE OF SPECIAL ED APPE

And, what I really don't get is, this Administration convinced us to pass No Child Left Behind in 2001, and IDEA was reauthorized in 2005, and the 40 percent figure was still in it. If they didn't intend to fulfill the commitment, then why did they come in and support a reauthorization level of 40 percent. Why didn't we just zero it out then?

Secretary SPELLINGS. As I said, the approach of the Administration has been to prefer programs that are large in nature and have a lot of latitude for States and local districts—IDEA, Title I, Reading First and the like—over programs that are small in nature and small in scale, and that, with respect to the PART process, OMB's performance review, have been ineffective. And so, there is a lot of latitude around those larger programs.

All of the increases in these larger programs can be used on Native Americans kids, rural kids and so forth, and that provides more local control, preferred over particular silos of individual programs.

EFFECT OF IMPACT AID PROGRAM CUTS

Mr. REHBERG. But with Impact Aid, we have no ability. We have no tax structure because it is federally-owned property or tribally-owned property. There just is not the ability to replace that based upon the local taxing authority.

And so, when you don't show a commitment there, you are just undercutting any of the successes that you might have seen in No Child Left Behind. It shows a fundamental either misunderstanding or contempt for those of us who have large Federal properties or tribal properties within our State to continually hang on thinking, well, No Child Left Behind will come in and fill the void. It just doesn't.

I don't know what you guys are smoking over there, but it ain't working. It just isn't working, and so maybe a new Administration with new leadership will get it because it is just really frustrating to see our tribal schools falling further behind while No Child Left Behind is supposed to be the answer. It isn't working.

Hence, I voted to override the President's veto and will continue to do it again as a Republican.

Secretary SPELLINGS. All right. [Laughter.]

Mr. OBEY. Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman.

Good morning, Madam Secretary. Let me ask you a couple of questions.

UPWARD BOUND EVALUATION

First of all, as you know, for nearly a year the Congressional Black Caucus has been concerned about this evaluation study or this evaluation that was really basically flawed and that some students in a control group—this has to do with Upward Bound—would never again be able to participate in Upward Bound. And so, last year in the appropriations bill, we included language that really barred funding for this study.

Lo and behold, we found that the study was continuing anyway, and we wrote you a letter. Subsequent to that, we received a copy of a letter to Upward Bound grantees, indicating that now it would be best to terminate the evaluation.

So I just want to clarify what happened. Why did you continue with this.

You knew what the intent was of Congress to stop this, and it took a letter by several of us to write to you to be able to get a response. I still don't know if the grantees have received that response yet. This was a copy of a letter.

So that is the first question.

Secretary SPELLINGS. They have.

Ms. LEE. They have?

Secretary SPELLINGS. They have been notified that the evaluation has ceased.

I would just say that this is the only program under the jurisdiction of the Department of Education that has a prohibition against evaluation. As a former State policy person where we invested State resources around Upward Bound and programs like that, not having the ability to make the case on behalf of effective programs I think is going to ultimately hurt.

Ms. LEE. Sure, but it was not being against the evaluation. It was the design of the evaluation and the discriminatory nature of the evaluation, and so that was the problem.

Secretary SPELLINGS. It has been canceled, and grantees have been notified.

Ms. LEE. Thank you.

BUDGET CUTS IN EDUCATION PROGRAMS

The second question I have has to do with this budget, and I just want to get your assumptions as it relates to especially low-income children, poor children and minority children and youth based on this budget.

I just want to mention a couple of the programs that have been cut: The 21st Century Community Learning Centers, that is after-school centers, down 26 percent. Safe and Drug-Free Schools State Grants, down, well, that is zeroed out. Mentoring programs, zeroed out. School counselors, zeroed out. Vocational education, zeroed out. Supplemental Education Opportunity Grants, zeroed out. Hispanic-serving institutions, down 20 percent. Historically black colleges, down 35 percent.

I mean what is going on as it relates to the commitment to educate children who don't have a lot of money, children who come from families who live in low-income communities, children who are minority and poor?

These cuts directly impact their educational ability, their ability to learn and to move forward and to develop the type of life that we want them all to develop in terms of the skills and knowledge, and so it is really cutting their educational opportunities.

We see problems all over the country now in school safety, violence on campuses. But mentoring, school counselors, safe and drug-free schools, those are certainly initiatives that help identify early on problems, children who need some intervention before incidents of violence break out.

I have to ask you, what do you all think over there? What is your rationale for all this?

EDUCATION PROGRAMS PROPOSED FOR ELIMINATION

Secretary SPELLINGS. There are 47 programs that are cut from the Department of Education budget. Twenty-seven of them are small in nature, \$25 million or less, and have been rated ineffective by the PART process and/or are so small in scale that it is hard to get critical mass around them.

Ms. LEE. So school counselors are ineffective?

EDUCATION PROGRAMS PROPOSED FOR INCREASES

Secretary SPELLINGS. In favor of, Congresswoman, investments in other programs like a giant Pell increase, and increases for Title I, IDEA, Reading First and programs that have a lot of latitude and flexibility for local school districts. Certainly Title I funds can be used for school counselors and those sorts of things.

Ms. LEE. Yes, they can be used, but they are not designated to be used for school counselors, mentoring programs, safe and drug-free schools.

You are saying now that if schools decide they want to use funds for these programs, they can. But if they don't, given the minimal resources and the choices that schools have to make, why in the world would we put the squeeze on them like that?

BUDGET TRADEOFFS MADE FAVORING LARGER PROGRAMS

Secretary SPELLINGS. Well, as I said, a couple of answers are, one, the programs are found to be largely ineffective by virtue of the OMB performance review process and, secondly, they are so small in nature that it is hard to get critical mass around those sorts of activities.

You mentioned safe and drug-free schools. There is a preference toward statewide activities, and this is certainly what we saw in the aftermath of Virginia Tech, that can be more strategic, more effective because they are looked at in the context of State laws and so forth.

Ms. LEE. And Hispanic-serving institutions, historically black colleges cuts?

Secretary SPELLINGS. With a very large and substantial increase in the Pell grant. As I said, tradeoffs have been made with a preference toward large programs.

Ms. LEE. Thank you, Mr. Chairman.

Mr. OBEY. Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman.

I appreciate the good job you have done, Ms. Secretary.

Mr. Chairman, I want to submit a number of questions for the record, but I will have a few here.

CONNECTION BETWEEN READING FIRST AND SPECIAL ED

I appreciate the fact that you made the point that Reading First is tied to special ed. I think we overlook the connection. The failure of one creates the problem in the other, and you are right on.

TEACHER INCENTIVE FUND

A couple things: Teacher Incentive Fund, what is the experience thus far of getting money to support teachers who are willing to go into very challenging situations in low income neighborhoods where it is so important to have that good teacher? Does this program help that to happen?

Secretary SPELLINGS. Absolutely, it does, Mr. Congressman, and thank you for your help in obtaining those resources.

There is almost \$100 million invested in a series of pilot programs, about 34 grants around the country. They are sometimes statewide efforts, such as Ohio is looking at urban school districts, rural communities, to find ways to get our best teachers doing our most challenging work.

We often do just the opposite in education. Our most experienced, most credentialed people are in our least challenging settings.

As you know, the program also focuses on principals in addition to teachers.

We believe that this practice is just being developed around the country, and that is why the President's request is to double that program to \$200 million so we can do more of that. We are just learning the best approaches, and I would be glad to share that with you as it is developed.

Mr. REGULA. Well, I am glad to see you recognized that with the increase, and it also leads to my second question. What is happening on the dropout rate?

ADDRESSING THE DROPOUT PROBLEM

One of the things that has really concerned me is the percentage nationwide of students that drop out, and I think part of it goes back to a failure to learn to read and perform. This dropout deci-

sion stems from first, second, third, fourth grade, and that is the reason we need to encourage these good teachers to go into those situations.

Are we making any progress in reducing the number of dropouts, a terrible waste of human capital?

Secretary SPELLINGS. Not enough is the short answer. Certainly there are places and States that are working on that, more customizing of education around those needs as well as helping struggling students, who have been left behind previously, catch up in basic skills like reading.

Really, our kids drop out for two reasons. One, they are unprepared to be successful in high school, as you mentioned. That is why we need to have a Striving Readers Program that can take some of this reading focus to our middle and high schools.

ADVANCED PLACEMENT PROGRAM

But also, it is often because kids don't see enough rigor or relevance in their high school, no reason to show up, and that is why the President has called for expanding the Advanced Placement program that can provide opportunities for kids to get additional training particularly in our inner city schools where we often ration rigor away from those communities currently.

Mr. REGULA. Well, I want to say those work because in my community the colleges are putting their faculty members in the high schools in order to inspire these kids to think about going on because a lot of them don't get much incentive otherwise to go beyond the high school.

Secretary SPELLINGS. Exactly.

Mr. REGULA. I think that program offers great possibilities in the dropout situation, and it has worked there. I think it is part of the P16 program which started in Georgia, which to me has a lot of pluses to make communities aware of this need.

TWO-YEAR COLLEGES

You don't talk about the 2-year colleges. We always think when we say college we think 4 years, and yet there are so-called junior colleges that offer an Associate's degree and a skill that they can take to the marketplace after 2 years.

Secretary SPELLINGS. Right, community colleges.

Mr. REGULA. Or, if they discover that they have an aptitude and desire for a 4-year diploma, they can move on.

Do you think we do enough to support and incentivize these 2-year programs that are growing in popularity?

Secretary SPELLINGS. They are growing in popularity, and they are very attainable and usually the most cost-effective option for students. That is why about 35 percent of our Pell recipients attend community colleges.

Mr. REGULA. That is interesting, yes.

Secretary SPELLINGS. They do work-related education that is very much related to the workforce, as you know, and I think that is developing around the country.

In places like Florida and North Carolina, they have done a lot of common course numbering and dual enrollment so that kids are getting a high school diploma simultaneously with an associate's

degree and the like, but the primary Federal investment in our community colleges, of course, is around the Pell Grant where many of those students attend.

Mr. REGULA. In our community, a technical institute which is just half of the community college, if you will—it is strictly an Associate's degree—has gone from zero to nine thousand in a relatively short time because people get on the bus and get there. If a company moves out, they can go and get a new skill and so on.

Secretary SPELLINGS. Exactly.

Mr. REGULA. I am glad to hear that we are moving on that.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. Roybal-Allard.

DECREASES IN PROGRAMS SERVING LATINO STUDENTS

Ms. ROYBAL-ALLARD. Madame Secretary, as you know, the Latino population is the largest and fastest growing ethnic group in the United States. In 2003, Latino children accounted for 18.5 percent of our Nation's total public school population.

As these numbers continue to grow, our country will increasingly look to Latino children to be a major part of our Nation's next generation of teachers, doctors, health care providers and entrepreneurs, and this is going to be a difficult task to achieve considering that Latino and other minority students are more likely to attend impoverished schools, demonstrate lower performance in core academic subjects and have a higher dropout rate than their white peers.

Now, the President's budget touts its \$30 million increase to the English Acquisition Program and its \$23 million increase to the Migrant Education Program. The fact is, however, that a mere \$30 million increase for English Language Acquisition does not keep pace with ELL enrollment, which has nearly doubled over the past 15 years. Nor will a \$23 million increase to Migrant Education begin to make up for the cuts that have been made to the program since No Child Left Behind became law. Consistently low funding for this program has also made it impossible to implement the Migrant Student Record Transfer System which is an essential tool for tracking severely at-risk and mobile migrant students.

Equally alarming is that the President's budget also dis-invests in other programs serving Hispanic and minority students that are critical to ensuring our country has an educated workforce that can compete in our highly technological and global economy.

For example, the President cuts \$66 million from Even Start, a family literacy program that serves many Hispanic families. It cuts \$18.8 million from Hispanic-Serving Institutions, which are the principal enrollers of Hispanic college students. The President freezes funding for the very successful HEP and CAMP programs which help migrant students graduate from high school and go on to college, and he cuts \$38.9 million from the Parental Information and Resource Centers, even though these centers provide a majority of Hispanic families with resources about college access.

Can you please explain the rationale behind cutting so many valuable programs especially designed to serve this extremely vulnerable population?

Secretary SPELLINGS. Congresswoman, thank you.

As you rightly noted, there are increases in some of those programs like the migrant program, of course, Title I and other things that certainly serve Hispanic students.

Again, based on the performance review process that OMB has established, we look at programs that are small in nature. We look at all programs and whether they are effective or not. The programs that are recommended for reduction or elimination are those that have been found to be ineffective with preference being given to larger-scale programs like Title I, IDEA, reading, Title II for teacher development and so forth, so that those kids can be on grade level by 2014, as No Child Left Behind calls for them to be.

I would also say just as a matter of policy—and I know you are aware that this is all being debated in Chairman Miller's Committee as we speak—that No Child Left Behind has done more to focus attention and resources and accountability around the needs of Hispanic learners than anything that I am aware of in the last 25 years I have been involved in this, and I think it is to the good of Hispanic kids.

We are just beginning to develop the right interventions, the right strategies and that, in my mind, is because of this intensity of focus that has been developed because of this law.

Ms. ROYBAL-ALLARD. Madam Secretary, let me just point out that the fact of the matter is that the President has created a Title I shortfall of over \$65 billion during his time in office and a near \$406 million increase is hardly impressive nor is it going to do the job that we need to do in order to educate our children.

That is certainly true when it comes to the programs that are important to Hispanic students. As we heard last year in expert testimony, unless that population is properly educated, this country is going to be in trouble because Hispanic students are going to be or should be an important part of our workforce.

Secretary SPELLINGS. Absolutely. Absolutely.

Ms. ROYBAL-ALLARD. I am afraid that this budget certainly does not recognize not only the important role that this next generation of Latinos and other minority students will play but the role our children will play in general.

Mr. OBEY. Thank you.

Mr. Simpson.

Mr. SIMPSON. Thank you, Mr. Chairman.

INCREASED FOCUS ON PUBLIC EDUCATION FROM NCLB

Welcome, Secretary Spellings. I agree with you. No Child Left Behind has done more to focus attention on education not only of Hispanic kids but of all kids than probably anything that has been done in years. That doesn't mean that it is perfect.

Secretary SPELLINGS. I agree.

Mr. SIMPSON. There are things that need to be changed in the reauthorization, and I know you are working with the appropriate committees on reauthorization.

Sometimes I don't think the President gets enough credit for really focusing attention, whether you agree with it or not, with focusing attention on education and the need to improve quality of education.

BUDGET REQUEST TO OMB

Let me ask you a couple of questions. First, what was your original request to OMB for your budget this year?

Secretary SPELLINGS. I don't know off the top of my head. As you know and I am sure are well aware, there is a lot of "toing" and "froing" between the Department and OMB as we settle on a final number.

Mr. SIMPSON. But I assume you put together the original request as to what you think is necessary to move the Department and move education forward.

Secretary SPELLINGS. Yes, sir.

Mr. SIMPSON. Then it gets whittled down as things go back and forth.

Secretary SPELLINGS. In the context of other priorities and other competing agencies and so forth, yes.

Mr. SIMPSON. You don't know what the original request was at least?

Secretary SPELLINGS. Well, I certainly can find out. I don't know off the top of my head.

Mr. SIMPSON. Could you get that information for us?

Mr. SKELLY. We can provide that, Mr. Simpson.

Mr. SIMPSON. I would appreciate it. I would like to see that.

CAREER AND TECHNICAL EDUCATION

One of the other things that bothers me a little bit, as you know, we have the Idaho National Laboratory in Idaho.

Secretary SPELLINGS. Yes.

Mr. SIMPSON. As I talk to companies, nuclear companies and so forth, the one thing they say that is going to hold back the advancement of nuclear energy and so forth in this country is the lack of technical skills of welders, electricians, those types of individuals, because we aren't training them, and you have eliminated the career and technical education part in your budget.

Secretary SPELLINGS. As you know and as I have said, we look at programs and whether they are effective or not. One of the things that we were encouraged about is more alignment with rigorous academic skills and so forth in our vocational education programs, but we have yet to see that. That is why, again, we focus on investments that are effective, Title I and others, in favor over those that have proved to be ineffective to date.

MATH AND SCIENCE EDUCATION AND TEACHER TRAINING

Mr. SIMPSON. What are you going to do to meet those demands that are going to be coming up?

Secretary SPELLINGS. Well, the President has called for expansion of the Advanced Placement Program to provide more rigor in math and science and other subjects in our high schools.

He has appointed, and actually they will soon conclude their work, a math panel to look at the best research, the most effective practices that can be shared with educators about how we can be better in that area.

Obviously, we need to focus on teachers. As you are well aware, many of our teachers, particularly in math and science fields in the

elementary and middle school levels, are not sufficiently rooted in those areas to be effective, and so there is a major focus, obviously in Title II, for professional development.

But, frankly, we have seen good gains on No Child Left Behind in the math arena that have really outpaced reading. So there are really some signs for encouraging feelings because of the increases that we have seen so far.

NARROWED CURRICULUM FOCUS

Mr. SIMPSON. One of the things that concerns me, quite frankly, and I agree with the emphasis on math and science. We need to do that, but I think we are leaving other parts of education behind by doing that.

You are seeing programs dropped in schools. I think the arts are important in schools, but you are seeing more and more of those dropped, and less emphasis on those programs as money is diverted into math and science and other things. We need a well-rounded education, not just a math and science geek, if you know what I mean.

TEACHER RECRUITMENT

The other thing that really concerns me is if you look at the number of teachers in this country that are aging and could qualify for retirement or will retire within the next 10 years. What are we doing to replace those teachers and make becoming an educator an important choice when someone goes to college?

You have to have a quality teacher at the front of that classroom. That is not the profession that a lot of students are choosing when they go to college now.

COLLEGE COST REDUCTION ACT AND TEACHER TRAINING

Secretary SPELLINGS. You all, as part of the CCRA last year, took some steps to provide additional loan forgiveness for teachers or prospective teachers who want to enter the profession. We are in the rule-writing process and addressing that to, obviously, try to recruit and retain more people into this profession.

Also, obviously, support for Teach for America and Troops-to-Teachers, other programs like that provide resources to get folks, effective folks into our classrooms.

EDUCATION CURRICULUM—FEDERAL ROLE

With respect to this narrowing of the curriculum thing, I think obviously our attention and what we all look at in education, is what is the Federal role as a 9 percent investor in this enterprise. What is the point of entry? For 40 years, it has been around our Nation's poor kids.

Mr. SIMPSON. Nine percent participant in terms of funds, but what percent in terms of direction, rules and regulations?

Secretary SPELLINGS. It is around reading and math, getting kids on grade level by 2014. We don't have a giant title program centered around arts and science, arts or other programs.

So I would say this is a necessary but not sufficient first step. This is a shared partnership with States and localities, and I think

they are adapting with our focus on achievement for everybody in the context of the other things they want and should do.

PELL GRANTS FOR KIDS

Mr. SIMPSON. Let me ask you one question as time runs out, quickly. The Pell Grants for Kids program, that you have proposed, a cute name for a voucher program for parents that want to send their children to some other school if they have a failing school, theoretically. What are you doing for those failing schools and the students we leave behind in those schools?

It is a very small percentage of parents that are going to choose to send their student to another school. What are we doing for the resources for that school that we left behind?

SCHOOL IMPROVEMENT FUNDS

Secretary SPELLINGS. Asking for \$500 million in additional school improvement funds to, as I said, to triage some of those schools.

One of the things that we are debating, again as a matter of policy, are ways to make distinctions across the accountability spectrum between those chronic under-performers, 5 or more years of not making it, and those in-range schools. And so, additional resources ought to be spent on those that are nearing that sort of condition.

However, those kids who have been in those schools and on those campuses for 5 or more years need a lifeline to a different, better opportunity. I was encouraged that Congressman Emanuel is about to introduce something that is that notion for charter schools, so that kids can take resources with them to charter schools outside their district.

Mr. OBEY. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman.

Welcome, Secretary Spellings. I appreciate your being here.

INCONSISTENCY IN EDUCATION FUNDING PRIORITIES

I guess you wouldn't argue the fact that public education in this country is critical in terms of having a good, strong democracy.

Secretary SPELLINGS. Absolutely.

Mr. HONDA. You probably wouldn't argue the fact that having a strong public education in this country is akin to a good national security policy too.

But your written testimony is very confusing to me because you say that it is a push ahead budget, yet there are astonishing increases in different programs. So if that is the case, then there must be astonishing cuts in other programs.

You just mentioned that you have cut something like 27 programs that are \$25 million or less because they were duplicative or they didn't prove to be successful. The question I have regarding that is you established a program where you took some money out of a teacher improvement program that was larger and more flexible and successful. You took \$100 million out, and you created, what did you call it, a Teacher Incentive Program?

Secretary SPELLINGS. Teacher Incentive Fund.

Mr. HONDA. Yes, and you created a smaller program that hasn't been tested. How does that match the comments that you are making when you cut close to \$625 million out of smaller programs?

Secretary SPELLINGS. Well, clearly, those are resources that are developed around teachers and teacher needs. As Mr. Regula—

Mr. HONDA. Excuse me, but the money out of the program from which you took has the same direction and same mission, it seems to me. And so, it sounds like you have a reason for cutting programs, but then you create other programs that seem to fit the same characteristics.

You cut ESEA funds for elementary. You put it as secondary. I don't know how you sustain a good district-wide program when you take money here, and you put it back up over here, and then you leave the lower grades where a lot of that work is needed and expect any kind of growth for those students.

Then the minority-serving institutions, higher education institutions, you cut them by 27 percent. You said, but we provide. I assume you are saying you provide an equal amount of money for Pell grants, but the Pell grants are for students and that money goes back into the institutions. But institutions need the money just to maintain their functionality.

It just feels like you are setting up a system that is going to be, at best, nonfunctional or is going to have a difficult time trying to meet its goals.

The other thing is I guess the \$300 million Pell Grant for Kids scholarship, that in itself, the way you describe it, is really money for people to escape a situation. I am not sure what that really addresses. It is not really a lot of funds for those students who are Latinos. I would like to see the numbers for how the demographic breaks down in terms of the types of kids that are leaving.

There is a lot of inconsistency in your budget, and I think that the amount of money that you cut out of programs, the 27 programs, amounts to about \$625 million which is about the same amount of money that was put into other programs.

ACADEMIC COMPETITIVENESS AND SMART GRANTS PROGRAM

There is a program you were responsible for that you talked about, the Smart Program, something like that.

Secretary SPELLINGS. AC/SMART grants, the Pell enhancement or advanced placement program.

Mr. HONDA. Right, and that has something like \$960 million in it?

Secretary SPELLINGS. Yes.

Mr. HONDA. How much did you return back to the budget?

Secretary SPELLINGS. Six hundred and fifty million dollars.

Mr. HONDA. So, essentially, a good proportion of that money was never touched.

Secretary SPELLINGS. Because we didn't have enough kids who were qualified.

Mr. HONDA. You didn't have enough kids who qualified?

Secretary SPELLINGS. That is correct.

Mr. HONDA. Well, did you have a system that was well designed so that people knew that it was available?

This was supposed to be on top of Pell grants also?

Secretary SPELLINGS. It is. It is on top of Pell grants.

Every State has certified. The law calls for them to certify in conjunction with me a rigorous course of study that makes them eligible for this additional financial aid.

The first year it was enacted it was about an \$800 million program. By virtue of these various State programs, who they identified, who had taken those, the kids who had taken those programs, we spent about \$450 million of those resources.

Mr. HONDA. And then this time, you spent even less than that.

Secretary SPELLINGS. Based on the kids who are taking these programs. It shows us the need to continue to work on our high schools. I grant you that, absolutely.

Mr. HONDA. It is interesting to me.

Mr. OBEY. The gentleman's time is expired.

Mr. HONDA. Thank you.

Mr. OBEY. Mr. Peterson.

Mr. PETERSON. Good morning. Secretary Spellings, I would like to thank you for your public service.

Secretary SPELLINGS. Thank you, Congressman.

NO CHILD LEFT BEHIND FOCUS ON EDUCATION

Mr. PETERSON. I think the Bush Administration's introduction of the concept of No Child Left Behind has probably been one of the best academic debates in this country and hopefully will continue to be because we shouldn't leave anyone behind. We shouldn't even think about it.

CAREER AND TECHNICAL EDUCATION

But I will say, yesterday the House passed a resolution honoring the goals of Career and Technical Education Month. I want to tell you in my view, and I have been on this Committee throughout the Bush Administration, those that are technically gifted in America do not have equal access or opportunity to an education as those who are academically gifted.

Ninety percent of the companies in this country employ people who are trying to stay here, trying to compete here and not move offshore, are screaming for skilled workers. Your budget, year after year, puts a zero priority on technology education.

Fifty percent of the kids that attend my schools and the teachers I talked to in the classrooms I visit, don't know what academics are. They don't know what the word means. They are attending school. They come from poor families. They are struggling. Nobody is telling them that they need to get a good education and they need to go to college.

But our whole program is about those who are going to college. I am all for them, but half the kids that are attending our schools don't know even the possibility of a college education in rural America. They are just attending school.

A lot of them are technically gifted. They are born with the skills to take things apart, fix things, and it is amazing to watch how technically gifted some kids are, but this Administration doesn't value that.

RELEVANCE OF ACADEMICS SEEN THROUGH TECHNICAL EDUCATION

Those are the people that run our factories. Those are the people that make things work. I have seen a lot of kids. When you put highly modern, technical classrooms in a school, the poorest among us get excited, and then academics become relative to them when they learn how to do something.

I will never forget when I was in a computer classroom to repair computers. It was a very poor school in my district, and I had gotten them some funding and they put in a computer repair program.

The kids that were in there, and I asked the class, how many of you have a computer at home? Seventy percent of them didn't have a computer at home. They were poor kids, but they were excited because this one kid said to me and I will give his exact words.

He said, I tore this sucker apart. Those were the words he used. I put in a new motherboard, and I put in this, and I plugged it in, and it worked.

Computers are going to be relevant in the rest of his life, just repairing a computer. Information now is important to him.

This Administration has just written that all off as a waste of money, as a waste of time. Folks, that is the engine that will drive this country economically. We are not short of academic people to run things. We are short of people to do things.

The cars of today have 50 to 100 computers in them. When I was growing up, you learned to be a mechanic in the backyard because you were poor and you were always working on your dad's car. That was how you became a mechanic.

Not today. You have to go to a certified school. It needs to start in high school, not at college level.

PLC, what is a PLC? A program logic controller, it is a computer that runs a machine in our manufacturing plants. I have 20 counties. I don't have a school that teaches how to repair a PLC, a program logic controller, a computer that runs a machine. We have to bring in technicians from out of the area because we don't teach them.

I talk to every growing company in my district. Their number one problem is skilled workers because they are only growing because they have invested heavily in modern machinery. It takes skilled people to run it, not academicians.

But when young poor people, specifically, get skilled training so they can accomplish something, then the academics become relevant to them.

I think you have it backwards. The dropout rate in the cities would be a lot less if they had skilled training there for the kids who can do things with their hands.

Over half of Americans shouldn't be academicians. Twenty-three percent need a college education, theoretically. More than that is better. But our whole focus, your whole focus is on academics, and you have thrown the baby out with the bath water by continually de-funding technology education.

I would be interested to hear your thoughts.

ACADEMICS AN ESSENTIAL PREREQUISITE TO TECHNICAL EDUCATION

Secretary SPELLINGS. I would grant you that there is absolutely an emphasis on grade-level achievement in reading and math as the absolute necessary requisites to be successful in a modern manufacturing plant or in any kind of endeavor, technical or otherwise. It is not a skill. Basic literacy is not a skill that is only for the college-going, and we are a long way from doing that.

In fact, these new technologies that you describe require virtually algebraic knowledge and experience to work in those sorts of arenas. An ability to read and cipher on grade level is an absolute prerequisite to success in that and every other endeavor.

Mr. PETERSON. But when the Federal Government abandons technology education like you have, we won't have technology in the schools.

We don't fund the majority of our schools, but the Federal Government has always been the leader of what we ought to be doing. We are the idea, and then the States partner with our money. To get our money, they do what we think they ought to do. That is what they do.

We give them a little bit of money to lead them down the road, and you are saying technical education is not important because you don't fund it.

Secretary SPELLINGS. We have spent more than \$30 billion through the E-rate tax.

Mr. PETERSON. That is not appropriated money. That doesn't count. You can't get by with that. I am sorry.

Technical education has not been a priority of the Bush Administration, and it just astounds me.

Mr. OBEY. The gentleman's time is expired.

Mr. Jackson.

Mr. JACKSON. Thank you, Mr. Chairman.

Secretary Spellings, thank you for your service to the Nation.

FEDERAL ROLE IN EDUCATION

Let me first begin by saying my attitude and disposition about this budget is not too far from what I heard Mr. Peterson say, and I want to begin with a little context.

I heard one of my colleagues say, what is the appropriate role of the Federal Government in education, and I want to put all my cards on the table for my colleagues, both on the Republican and on the Democratic side of the aisle and certainly for you, Madam Secretary.

I believe our role as a Committee and as elected officials is to build a more perfect union amongst the States.

CLOSING THE EDUCATION ACHIEVEMENT GAP BETWEEN STATES

It is the States, from my historical perspective, that have created the separate and unequal education system.

It is poor children and their families. It is African Americans and their families. It is Latinos and their families. It is the disabled and their families. It is young women and their families who petitioned their government to close the gap that exists between the States and their opportunity in our public education system.

It is not the Federal Government that has maintained that separate and unequal system. I could go back through our Nation's very troubled history on this question. We have even sought the intervention of the Federal courts to try and close gaps between certain sides of town and other sides of town, to close the profound gaps that exist in education.

As the Secretary of Education, I see your role—and maybe I am getting this wrong, Mr. Chairman—as the primary champion for the Federal Government in closing the gaps in the States.

We don't need a States Righter, someone coming to us or even members of this Committee, arguing that the Federal Government should have a limited role and the States are doing a good job. They are not doing a good job. They are separate and they are unequal.

In fact, this Committee actually funds a number of studies that actually rank the States, and every year that we serve on this Committee we hear who is doing the best job, number one all the way down to number 50. So there are 49 States every year that are not quite in the number 1 position.

And so, the American people petition their government through our Committee, through this budget and through this appropriations process to close the gap in the States so that all of our children, whether they are in Idaho, Massachusetts, whether they are in the southern part of the United States, the western, the northeastern part of the United States, to close the gaps that exist from access to quality, to books, to size of classrooms to teacher quality to teacher training to access. You name it.

So in the final analysis, if we are not interested in building a more perfect union amongst the States, we ought to just say that because this budget does not reflect in some of the cuts and some of these programs do not reflect that we are trying to close the gaps that exist in the States.

If we are the Committee of last resort to giving all of the American children an equal opportunity in the States, then yes, we have to fund the technical assistance programs that Mr. Peterson is talking about. We have to fund the career opportunity programs that I am talking about and the GEAR UP programs and the TRIO programs because the States don't have comparable programs that can give children an equal opportunity to participate in the Nation's education system.

So let me first start with my premise even though I recognize that my time will expire before I even get to the questions because once I lay out the premise, once I lay out the premise, then this is a bunch of garbage.

I don't mean to say that the staff has not put in significant work, but the premise is wrong, that there should be some limited role of the Federal Government when we are the body of last resort to give children in our Nation's public education system some opportunity in the States.

The great tragedy of this Committee is that we rank the States, the best State versus the other 49 States that need to catch up to the best State every year, and then we come back and talk about whose State is number one and whose State is number 50 with

Mississippi usually being consistently number 50 and then my State, 19, 20 or whatever it is.

Then I come here, arguing for more resources to close the gap between my State and the number one State only to be told through some budget process or through some President's budget request that there is never enough money to close the gap for the children during the educational life of my constituents in the course of a given process.

VOUCHER PROGRAMS

So, with that said, I have questions about the proposed Pell Grants for Kids program. The President is once again requesting \$300 million for a school voucher program tied to No Child Left Behind despite Congress' repeated rejection of the idea.

Why does this Administration continue to attempt to funnel Federal tax dollars to private schools with no pretense of requiring those schools to adhere to the very same public accountability standards by which our public schools continue to be judged?

Lastly, oh, my time is expired.

Mr. OBEY. You can take 20 seconds.

Mr. JACKSON. I appreciate that. I will yield my 20 seconds to the Secretary for the answer, and I will submit the rest of my questions. [Laughter.]

I will submit the rest of my questions for the record, Mr. Chairman.

Mr. OBEY. We will run a slow clock on you, Ms. Spellings.

FOCUS OF EDUCATION IS ON EVERY CHILD

Secretary SPELLINGS. All right. Thank you, Congressman.

I can assure you I am the primary champion for leveling that playing field. That has been the 40-year role of the Department of Education in the Federal Government. Title I, IDEA, these programs were created on behalf of poor and minority kids, and that has been the expectation.

Six years ago, when we passed No Child Left Behind, we said to ourselves: We are for real. We mean it. We are going to hold the schools accountable for at least grade-level achievement by 2014 for every one of those kids by disaggregating data.

And, I can assure you there is discomfort in the States in many places because of that focus on every single child. I don't dispute that at all, and it has been powerful.

ADEQUACY OF EDUCATION RESOURCES

With respect to resources, as you know, this is a perennial discussion between all of us. Funding is up 63 percent in Title I and No Child Left Behind since the President took office. Is it enough? We will continue to debate that, obviously, but I can assure you disaggregation of data has done more to attend to the needs of poor and minority kids than any policy we have ever put in place.

Mr. OBEY. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman.

Budgets, as my colleague from Connecticut suggests a lot, Ms. DeLauro, reflect our values. I think from the looks of what you

have submitted here and what the Administration has submitted here, I think we have clearly a set of different values as to where we should put our money.

I think in some instances when you say we are cutting these programs of \$25 million or less or some of these programs, Advanced Placement, the mentoring, that don't have a lot of money in them and then somehow suggest that they are not working and if you think that \$50 million is somehow going to provide enough money to have a successful mentoring program in the United States of America, given all the challenges that we have, I think is an unfair assessment of what is going on here because there is just not enough money in there for it to be successful.

So I don't think it is an adequate representation of whether or not the program would succeed. The question should be would it be a successful program if it was adequately funded.

So I just want to join my colleagues here to say I don't think this reflects the values of the Committee and, as we did last year, I think there is going to be a lot of changes made here.

TECHNICAL EDUCATION AND 21ST CENTURY AFTER-SCHOOL PROGRAMS

I want to add one comment to enjoin Mr. Peterson and Mr. Simpson on the career and technical side, critical in northeast Ohio, old manufacturing. We are looking for new things to do. Energy is a major component of that. Getting these kids engaged in the learning process, that is the trick. You learn to love learning, and then you will be fine regardless of where you end up.

And so, with that, I have just a couple of quick questions. One is the 21st Century Learning Opportunities. Mr. Regula mentioned dropouts, and I think your comment was that yes, of course, you were against it. This is an after-school program. This is one of the key programs I think that would prevent kids from dropping out.

My question is this: We have in a couple of our schools locally, in Warren, Ohio, Warren Harding has a great robotics program, just phenomenal. I mean you want to talk about lighting kids up and getting them interested in learning. You throw a bunch of stuff on the floor and tell them to put it together, and all of a sudden they are engaged in the learning process, what Mr. Peterson was saying earlier.

My question is in this 21st Century Learning Opportunities, although there is a cut of \$300 million, is that something that a robotics program, a local robotics program could access and be a part of?

Secretary SPELLINGS. Potentially, yes, Congressman. We also have a kind of programmatic change to make this program look more like the supplemental service program where parents take that amount of resource and spend it where they like. And so, clearly, programs of multiple different approaches and designs are eligible for this sort of funding.

Mr. RYAN. You would say the robotics program would fit into this?

Secretary SPELLINGS. I would have to, obviously, know more about the program and whether it meets the other requirements and so forth but potentially, yes.

Mr. RYAN. Okay. Well, they compete in the national first robotics competition.

ENVIRONMENTALLY-FRIENDLY, ENERGY EFFICIENT SCHOOLS

Lastly, as I am sure time is winding down here, one of the issues we have in Ohio, as I am sure a lot of other States are having, they either secured or got a lot of money from the tobacco settlements and they put that money into the schools.

One of the issues is the schools, not only the new schools but the older schools. They are not really environmentally friendly. They are not really energy efficient. They don't have the best and latest technology for conserving energy.

I know there are some Youth Build green programs that are just starting to pop up around the country. Is there anything that you are doing to try to help these schools save money energy-wise, use the school as a laboratory in a sense where, as the school is updating and becoming more energy efficient, that is actually a kind of laboratory for these kids to learn about alternative energy?

Are you doing anything along those lines?

Secretary SPELLINGS. Actually, my colleague, Sam Bodman at the Department of Energy and I have partnered together on some of that sort of thing, although the programs themselves are in the jurisdiction of the Department of Energy and are not under our budget. But there are some new models for energy-efficient construction and they are all over the country now. I know you are aware of that, but that is all under the jurisdiction of the Department of Energy.

EDUCATIONAL VALUE DERIVED FROM ENERGY EFFICIENT SCHOOLS

Mr. RYAN. Okay. I just want to suggest the more we can make these schools into laboratories and places where these kids, where everything that is going on around them is teaching them something or trying to stimulate them in some way, the better.

At Oberlin College, they have an environmental science building that has been carbon neutral for years now, but the carpeting is recycled. The lights go on only when the motion sensor goes off. The heat and the cooling is regulated by the number of bodies that are in the room, all of these things.

I don't even want to say this, but they recycle the toilet water into a fauna system. I wish you would gavel me down right now, Mr. Chairman, before I get too into this. [Laughter.]

Mr. RYAN. But the whole building is a laboratory for this kind of 21st Century education.

The more we can do that, especially in the communities, as Mr. Peterson suggested, that aren't used to the technology, aren't used to these kinds of things, I think the better off we are going to be. We only have 300 million people in the country. We need them all on the field, playing for us.

So I appreciate your coming.

Secretary SPELLINGS. Thank you.

Mr. OBEY. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman.

Thank you, Secretary Spellings for being here.

GEAR UP AND TRIO PROGRAMS

On the GEAR UP program and the TRIO programs, I have seen these firsthand in the communities across my congressional district and seen how good they are in terms of tutoring, in terms of mentoring, the college scholarship part, but it just seems that there is a disconnect here with the Administration because in recent years the discretionary funding for these programs has declined significantly in both nominal and real terms.

Is it that you don't believe these programs are effective or where are you coming from on this?

Secretary SPELLINGS. They are flat-funded in the President's budget. They are not reduced.

Mr. UDALL. Yes. Yes, I know they are flat-funded.

Did you believe there?

IMPORTANCE OF COLLEGE AWARENESS AND PREPAREDNESS PROGRAMS

Secretary SPELLINGS. Well, I certainly do believe that high school college awareness programs are something that we need and these connections between postsecondary education and higher education are critical.

I would say that as we look at reauthorizing No Child Left Behind and collaborate with the authorizing committee about what the policies and what approaches, what accountabilities, and what our policy points of emphasis should be as part of the reauthorization on high school, that we ought to align our philosophy and the program resources we invest, including TRIO and GEAR UP and other things, around that philosophy.

It is right before us at the moment.

Mr. UDALL. The philosophy, as I understand it, is to encourage at-risk students to graduate from high school and prepare for college, and that is what you have been saying here, that the focus of the Federal Government has been to do that. That is where we target the money.

And, yet, you flat-fund these programs. What is going on there?

Secretary SPELLINGS. Well, I think the question is: Are those the most effective and efficient ways to do it and are they in keeping with whatever policy we will embrace as part of a reauthorized No Child Left Behind?

Are we going to ask our schools to expand rigor? Are we going to ask them to focus on reading? What are the other things that are before us, which is why the President has recommended flat-funding those programs until we determine where we go next as a matter of policy.

Mr. UDALL. Thank you.

INDIAN EDUCATION AND TRIBAL COLLEGE FUNDING

I want to agree with Congressman Rehberg from Montana earlier where he talked about Indian education and Indian funding and tribal colleges.

I see, talking about Hispanic-serving institutions, tribally-controlled colleges, we have a cut in there of \$139 million, 27.2 percent below last year's level. That doesn't make any sense to me. I note that funding for Indian education programs is flat at \$119 million.

Are you aware of the challenges that our tribes face?

Flat funding is simply standing still, which is nowhere enough to make the progress we need to against the challenges. Could you comment on that?

Secretary SPELLINGS. Yes, sir. As part of the appropriations bill last year, there are mandatory funding streams that support those institutions, and so we believe that these programs are adequately funded through those other funding mechanisms on the mandatory side.

Mr. UDALL. Are you aware that most of these tribes have a very, very young population that is a growing population?

This young cohort that is moving through needs significant help in terms of these kinds of programs, and it is the one place where young Native Americans and African Americans and Hispanics can learn from each other and then go on and be very productive. So do you believe these are effective, good programs and should be expanded and moved forward?

Secretary SPELLINGS. As I said, they are funded on the mandatory side and are part of the President's budget in that regard. So I mean, yes, I think value can be had from some of those programs.

Mr. UDALL. Well, let me just say from my perspective that I really believe that the President's budget on education is so lacking when it really comes to supporting the needs that are out there.

I hope. Mr. Simpson asked for what your original request was. I sure hope your original request was a lot more aggressive than what we see in this budget.

Then let me just note finally that mandatory increases only apply to tribally-controlled colleges, not Indian education. So, with that, if you want to make any further comment, that is fine.

Secretary SPELLINGS. I would just say I certainly will provide that letter, but that was before we had a final budget. So I would just want that to be looked at in the context of where we ended up versus where we thought we were ending up last summer when we were beginning the negotiations with OMB.

Mr. OBEY. Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman.

Welcome, Madam Secretary. I apologize for being late, but there are all kinds of hearings going on.

Secretary SPELLINGS. Yes, I bet there are.

VOUCHER PROGRAMS

Ms. DELAURO. First, let me just correct the record, and I haven't had an opportunity to talk with him—he usually speaks for himself and does it very well—but Congressman Emanuel is not introducing a voucher program nor would he take money from public schools to utilize those funds in private schools. As for the many years that I know him and where he stands on public education and in support of public education, I think it is a little bit of a mischaracterization and a little bit of innuendo about what direction Mr. Emanuel is going in.

FEDERAL EDUCATION BUDGET PRIORITIES

Let me further state that you can say and you can write down that education is a priority. You can go to schools, and you can

take pictures with youngsters and talk about how much you care about their education and their future. Something that my colleague from Wisconsin, the Chair of this Subcommittee and the full Committee, has been known to state in the past, is that you can pose for holy pictures.

Quite frankly, the photographs and the budgets that we have seen in the last several years from the Administration with regard to education are, in essence, posing for holy pictures. In the parlance of today and with regard to the British comment about this, "it is all fur coat and no knickers" is what we have here.

And, when you begin to go down the list, I say this with annoyance. I say it with anger, and I say it as a kid whose family would have not been able to get her to school but for the work that they did and the opportunity from the Federal Government to make it a reality. So I can sit in this chair, and I have the opportunity to look at public policy and try and do something about it.

We have a role, and that is where fundamentally the problem comes with this Administration and, I believe, more and more with Democrats and Republicans as was pointed out by Mr. Peterson. We have a role. We, government, have a role to engage in issues that make opportunity real for people, and education is the single biggest opportunity that we can make real for people in this Nation. It is their road to success, and that is what it is about.

Watch what Mr. Eisenhower said here, and you look at it, and you understand who we are and what we are about.

I will just say to you flat out, over the last several years—and you can get annoyed at me. I am glad this is the last budget on education. I am glad because what we have seen day in and day out, year after year, is posing for holy pictures.

No Child Left Behind, you can talk about \$63 billion, 63 percent. The facts, it is all in the facts: \$86 billion shortfall for this program.

Mr. Peterson's comment, why? You tell me why.

Help me to understand why if we are talking about competitiveness and increased need for high school employees. I went to my chamber of commerce in the Valley this week. They are crying for skilled people.

Why do you take a Perkins program and you just throw it out the door?

Why do you want to take an after school program and turn it into a voucher program?

Why is there no understanding of the essence of the Federal role in education and its ability to turn people's lives around?

Answer me on the programs: the shortfall on No Child Left Behind, the Perkins grant, vouchering the program for after school programs, eliminating 50 programs. How do you come here and tell us that education is a priority?

Secretary SPELLINGS. Well, as I said before you arrived, Congresswoman, the philosophy of the Administration has been to emphasize larger-scale programs like Title I, IDEA, Reading First and so forth over—

Ms. DELAURO. IDEA. IDEA? And you do travel around.

I don't know any special education teacher in this country that believes that what you have done to and what you are doing to

IDEA represents Mr. Ryan's comments about our values and how we want to try to educate children with disabilities. We are hurting those children.

I am not a special ed teacher. I am not, but I have listened to enough of them to know that your policies on IDEA and special ed are failures.

Mr. OBEY. The gentlelady's time is expired.

Mrs. Lowey.

Mrs. LOWEY. Thank you very much, Mr. Chairman.

Madam Secretary, welcome. I apologize with my colleagues, but we are all being pulled to different hearings today, but I am very pleased to have the opportunity to focus on two issues that I don't think have been addressed by my colleagues.

FEDERAL FINANCIAL AID CALCULATION FORMULA

As you well know, a student applying for Federal financial aid must complete the Free Application for Federal Student Aid form in order to determine how much his or her family will have to contribute towards tuition. Unfortunately, in many cases, families are expected to contribute much higher amounts than they can reasonably afford.

This is, in large part, due to the flawed formula used by the Federal Government which has not been significantly altered to reflect the changes in family spending patterns or the dramatic increase for necessary items such as health care in recent years. Even more shocking, the Federal Government does not take into consideration that some regions of the country, like New York, have higher costs of living.

So that means that a family in my congressional district, spending most of its income on housing or other necessities, may find that their expected family contribution is difficult or impossible to meet, leaving them with enormous gaps in their ability to pay for college.

EXPECTED FAMILY CONTRIBUTION FORMULA

If you can, explain to me why the Federal Government doesn't update its formula for calculating expected family contribution to better reflect the spending patterns of today's families and to take into account that some areas have a significantly higher cost of living and do you believe that it is fair to essentially penalize families who live in high cost regions of the country by not considering those additional expenses when calculating their expected family contribution?

By the way, and I am not going to get into the subprime crisis during this hearing, but there are those who have done a really important job on this. Their studies have shown that the majority of the money that families are spending is for mortgages and for health care.

So they don't have anything left. They are not going out to buy fancy refrigerators. They are not going out to buy TVs. It is all going to health care and to pay their mortgage, and this is what is happening in my district.

Why can't we realistically look at what a family is spending their money on and do something about the cost of living adjustment?

HIGHER EDUCATION ACT REAUTHORIZATION

Secretary SPELLINGS. Congresswoman, some of those changes were made as part of the College Cost Reduction Act which was recently enacted. As I know you know, the HEA is being reauthorized or discussions about reauthorization are going on now, and that is frankly in conference and nearing completion. So some of that is absolutely in the mix.

Mrs. LOWEY. And you have been advocating for cost of living adjustments?

Secretary SPELLINGS. Because, obviously, this gets down to sort of distributional type of politics, we in the Administration have not engaged as much on that as we have on the need for simplifying financial aid and to make sure that every one of our kids gets as much Federal aid as they can get before they turn to private sources. I think that is one of the things that is very important.

As you know, it is a highly complex and confusing system for families because of the 16 different programs. I am sure you have heard how difficult it is to even apply for financial aid. We are working to make sure that every kid gets all the financial aid due them and that we do that in a simple way as well as looking at legitimate cost differences around the country, as you all have prescribed for us under the CCRA.

21ST CENTURY COMMUNITY LEARNING CENTERS

Mrs. LOWEY. Well, I won't pursue that because we have limited time, but I want to mention another issue that I think you have to take direct responsibility for, and it was referenced by my colleague. Not only does the President's budget cut funding for after school by \$281 million, it radically restructures the program into a voucher type scholarship initiative.

Last year, when you came before the Committee, I informed you personally that the Port Chester-Rye School District—this is just one example—has just been notified that they will not be able to access additional 21st Century funds for its program. This is just one school that has been impacted by years of inadequate funding with the exception of the increase provided by this Committee last year under the leadership of Chairman Obey.

By one estimate, the President's proposal would close 10,000 21st Century Community Learning Centers.

If you could explain to me, how many students will be unable to access services with this level of funding, how many States would be unable to award new grants, and then if you could give me an idea of what I should tell these families, the educators, community leaders in my district that are in jeopardy for losing these programs?

According to the After School Alliance—my time is up, but if you could respond very briefly.

I don't understand this. This is such a good program. It makes such sense. I can't understand how you could actually in good conscience even think of cutting it.

Secretary SPELLINGS. The reason that the programmatic change is made is to align it with what we have done in No Child Left Behind, and that is the supplemental services, the tutoring that is a

feature of No Child Left Behind and that is based on a kid and his or her ability to select a variety of providers, or a family, a parent. This would make the after-school program look more like that which we do in Title I of No Child Left Behind.

With respect to the cut, as I have said, there are priorities in this budget that the President has established and other accommodations, reductions have been made to accommodate the priorities.

Mrs. LOWEY. So after-school programs are not a priority, I guess, to this Administration.

Let me just say, because my time is up, simplification is not the same as realistically looking at costs. It is my understanding, CCRA does not address this issue in the way that I am talking about to really look at costs. What it does is simplify the form.

So I do hope, Mr. Chairman, that we can continue talking about those two issues. But I am particularly distressed not just about the COLA but the fact that in a community like Port Chester, New York or Rye Town, New York, where I would say 85 percent of the people have two parents working and these after-school programs are absolutely critical in helping kids not only do their math and their English, their just basic, basic studies.

I think it is an embarrassment that the President should think it is not a priority.

Thank you very much.

Mr. OBEY. Thank you.

CONTEXT FOR REVIEWING EDUCATION BUDGET REQUEST

Madam Secretary, I just want to make, I think, three observations.

First of all, when we look at your budget request, I think we have to look at it in context. Here is the context that I see:

The President is asking us, according to Secretary Gates, to provide an extra \$170 billion for the misguided and misbegotten War in Iraq. The budget also allows \$51 billion in tax cuts this year to be provided to people who make over a million bucks a year. The President is then recommending on the domestic side of the ledger that we cut \$18 billion from program levels that we just approved in December for the previous fiscal year.

So he is asking us to spend almost 10 times as much in new money in Iraq as he is trying to cut out of domestic funding.

That decision comes in this context: Annual after tax income for the top 1 percent of Americans grew by 228 percent or \$745,000 per household between 1979 and 2005 while annual after tax income for the bottom 20 percent grew just 6 percent or \$900 over that 26-year period—900 bucks gain over 26 years.

So the rich got richer while the poor have been scraping by, and the same is really pretty much true of the middle class. That is the context in which we are considering these programs.

GEAR UP AND TRIO PROGRAM BUDGET REQUESTS

Now most of these programs are aimed not at that top 1 percent but at the bottom 40 percent of people in this society. You mentioned that you had flat funded TRIO and GEAR UP. The problem is that since 2002 those programs, as I understand it, are serving about 450,000 fewer students.

Your own budget submission, this document, says that TRIO, for instance, is moderately effective. It doesn't say it is ineffective. It says it is moderately effective. That is better than adequate. It is certainly better than ineffective.

Yet, if you take a look at your budget which lays out on page 53, on the budget summary, number of student aid awards, there is a cut of 558,000 awards from 2008 to 2009 as I read it.

And, yet, we face the fact. One of the witnesses who will testify this afternoon says this: Only about half of the college graduates from the bottom 40 percent of the income distribution go to college within a year after graduation from high school compared to about 80 percent of those from the most affluent families.

So it seems to me that your budget contributes to the 20-some year trend in this country of widening the gap between the top dogs in the society and those on the bottom half of the totem pole.

Now Ms. DeLauro—and, God, I love her—she made the comment that education is the door-opener for opportunity.

TITLE I, ESEA

Your statement on the front page makes the claim that this Administration has generously supported key priorities that we believe are improving student achievement. You talk about how much more is in your budget in 2009 than was the case a few years ago for Title I, for Special Education, for Pell Grants, and you point out that your discretionary request for education is \$17 billion more than 2001.

Well, that may be true, but I think before you leave the impression that the Administration was in support of that, I think we need to look at the facts. Title I, it has increased by 59 percent since 2001.

But if the Congress had approved the President's request for Title I, \$502 million less would have been provided and when inflation and population growth are taken into account, the President's proposed 2009 Title I level falls more than \$650 million or 4.4 percent below the 2004 level.

SPECIAL EDUCATION

You talk about IDEA. We have had a number of comments on it. Nobody on the Subcommittee has worked harder than Mr. Walsh to try to increase that funding.

You talk about how much it has increased over the years, but if the Congress had approved the President's request for IDEA Part B, \$637 million less would have been provided than was actually provided.

EDUCATION DISCRETIONARY APPROPRIATIONS

If you take a look at discretionary appropriations for education in total, yes, they have increased by \$16.4 billion or 38 percent since 2001. But if Congress had approved the President's budget request for the Department, \$15.3 billion less would have been provided. That means Congress provided \$15 billion of the \$17 billion that you are taking credit for.

NO CHILD LEFT BEHIND

With respect to No Child Left Behind, I feel snookered on that program because I voted for it with the assumption that the Administration would make a good faith effort to meet the financial commitments that were implied in that authorization. I didn't expect full funding, but I certainly expected a reasonable effort.

Instead, after the first year, where I will fully admit the President stuck to the deal, since then the Administration has been in a rapid race against living up to the commitments of No Child Left Behind.

So if the Congress winds up not continuing that program, I think the Administration is going to have to look in the mirror when they ask the question why. Because you have walked away from your own program, and you have made it possible for people to attack that program for legitimate and illegitimate reasons.

But the driving force behind the anger and resentment that I hear about No Child Left Behind in my area is because of the lack of financial commitment on the part of the Administration. You have to recognize that whenever you flat fund a program, that means that the local and the State governments are being forced to pick up the cost.

You are really shifting costs back to the State and to your local school districts every time you flat fund a program because you are not allowing for inflation. You are not allowing for population growth. So the per capita assistance that is being provided in real dollar terms to people is steadily declining. That is not what I call a priority when programs are being treated like that.

READING FIRST

Then lastly, my last bone to pick is with the letter that you sent out to Chief State School Officers with charts, complaining about the fact that this Committee had cut Reading First and informing them what damage was going to occur to local districts because of those cuts.

Your letter didn't point out that the Department's own actions on Reading First caused the reduction in those funds in the first place, and it certainly fails to point out the other increases that this Committee provided for other programs. You know why Reading First was cut deeply by this Committee.

The President lectures Congress on earmarks that we make, and yet an earmark is nothing but directed spending. It is a decision by the Congress to direct a specific number of dollars from Point A to Point B or from Program A to Program B or from Community A to Community B. That is all an earmark is.

Every time your Department makes a choice about which community is going to get funded, which school district is going to get funded under Reading First, that too is directed spending.

The Inspector General had some not very nice things to say about the way that program was managed or I should say mismanaged by the contractor. He had some not very nice things to say about the lack of protection against conflict of interest in that program.

People talk about conflict of interest in the case of some members who have asked for earmarks, and they make a Federal case, and they attack virtually every member of Congress because a few idiots on Capitol Hill asked for funding which benefitted them personally.

Yet, if you take a look at what the IG said, it said that the Department still has not established controls to ensure that the Department does not promote curriculum or create the appearance that the Department is endorsing certain products. The IG found that Department officials deleted references in the 2002 guidance for the Reading First program to early intervention and reading remediation materials that could have been construed to permit such programs as Reading Recovery in the program which the Department opposed on Success for All and Reading Recovery.

Now those are two programs that have generally good reputations, and they have been validated as effective. Yet, they are still not seen as appropriate for Reading First in many States, and the Department has done nothing to change that.

So, if you are going to tell school districts that the big, bad Congress cut this wonderful, peachy program, then I think you ought to tell them why. I think you ought to understand that, just as the President has a right to criticize faulty earmarks on Capitol Hill, we have a right to criticize the mismanagement of programs that have effectively produced the same effect on the executive end of Pennsylvania Avenue. So I would appreciate if that message would be delivered.

EDUCATION FUNDING NEEDS TO BE COLLABORATIVE PROCESS

Lastly, having gotten that off my chest, I still want to come back to the point I made in the beginning. This year will either be a waste or it will be constructive, and that will be determined by whether or not both ends of the avenue are willing to make compromises.

If the President has sent down his education budget and says, thou shalt not raise my number one dime, as he said so many times over, then you can't deal with people who won't deal.

Let me put it bluntly. I can put together a deal with anybody if the other party wants to deal, but I am not about to waste the time of this Committee or this Congress or anybody in the country who is watching with a needless 8-month squabble over numbers if the President simply intends to stick by his original budget, not change a dollar amount, not change a comma.

What I would appreciate is if you will take back to the White House and to OMB a simple question: Do they want to work things out or do they want us to wait until a new President is in office who will act like an adult when it comes to negotiating?

That is very simply where I am coming from, and we will find out over time, I assume, where the White House is coming from. I hope they are coming from the right direction.

Now, if you want to comment, be my guest.

Secretary SPELLINGS. So noted, Mr. Chairman. Again, as you mentioned, all the various things you observed, the President did finally sign those previous budgets. I hope that that represents a

willingness to work with you, and I hope that that will be the case this year as well.

I will certainly carry your messages to my colleagues at the White House and OMB.

Mr. OBEY. Okay. Thank you.

Secretary SPELLINGS. Thank you.

Mr. OBEY. Mr. Walsh, do you have anything else?

Mr. WALSH. At the risk of pulling a scab off a wound, I would just like to make a point.

FEDERAL CONTRIBUTION FOR SPECIAL EDUCATION APPE

Ms. DeLauro, who is not here to defend herself, made the point that the Administration is at fault on IDEA. That may be, but the fact of the matter is that when Congress implemented this law they pledged 40 percent reimbursement to the school districts and for a dozen years at least, under a Democratic majority, they never exceeded 9 percent of that commitment or one-fourth of that commitment.

When we became the majority, we got it up. We doubled that to approximately 18 percent.

There is credit to be given, I think, to the Democratic Party for implementing this idea and guilt to be assigned for not meeting that commitment. We did our level best to increase that amount, and we did, and we could be criticized for not getting it higher.

But I think to hang this all on the Administration is absolutely unfair. We are the body that has the power of the purse, not the Administration.

There is a game played by every Administration, and that is they fund their priorities and they cut ours. Clintons did it, and the Bushes have done it.

Clinton, singular, I should say. I should not be prospective. [Laughter.]

Mr. WALSH. It is a game. It is part of the process. It is not the most delightful part of the process, but it is part of the process.

If blame is going to be given and credit is going to be given, we should share it equally on not meeting that commitment to our school districts and to those kids with disabilities.

Mr. OBEY. Well, let me just simply say I agree with the gentleman that, with respect to IDEA, the actions of both parties have been deficient, but we are dealing with the now.

The fact is that this Committee tried to make a substantial increase in IDEA last year. The effort to do so was vetoed by the Administration and the Administration's request this year does nothing to increase the Federal share of funding IDEA, which I regret. That is one program.

But there is no doubt if you take a look at the whole range of programs funded by this bill. The Administration, on many occasions, we have had to drag them kicking and screaming into accepting higher numbers. I think that is a fair statement.

But I do want to disagree with one thing the gentleman said. It may be seen as a game, but it is not a game with me, and I just want to tell one story to illustrate what I mean.

About six months ago, a fellow came into my office from Atlanta. He owns one of the largest chain store operations in the country.

He was also \$125,000 contributor to George Bush in the last campaign.

He came into my office, asking that I approve an increase of close to \$100 million above the Administration's request for buildings at the Centers for Disease Control in Atlanta, a worthy cause because a lot of those buildings are in bad shape.

I tried to explain to him that given all of the other shortfalls in the Administration's budget, that there was no way we could reach the number that he was asking for.

Then I said, look, why are you here seeing me? Why don't you simply go down and talk to the White House? I said, why don't you go talk to Karl Rove?

He said, oh, I already did that. But when I went in, Karl said, oh, don't worry about budgets. They are just a game.

No. I don't regard them as a game.

COMPROMISE NEEDED IN BUDGET PROCESS

True, games are played by everybody on Capitol Hill. There is a lot of role playing. Some of that is constructive, and some of it is destructive. But in the end, after all the games are played, we ought to be able to put aside our kitty toys and our tinker toys and make some compromises for the good of the order.

Mr. WALSH. Yes, absolutely.

Mr. OBEY. And that is what was absent last year. Last year, the Administration said, our way or no way.

Now they had their way last year. This year we got a safety valve. So if the Administration doesn't want to deal, if they don't want to compromise, if they don't like that word, then we are simply in a waiting game and we will deal with a President who does.

I hope that we can deal with this one because it would be good if we finished our work, so we didn't leave leftovers for the next President to handle. That would be very nice if we could get it done that way.

Thank you for coming, and I look forward to working with you.

Thanks, Jim.

[The following questions were submitted to be answered for the Record:]

ADDITIONAL COMMITTEE QUESTIONS**OUTSIDE CONTRACTS—
ANNUAL CONTRACT OBLIGATIONS FOR FISCAL YEARS 2000-2007**

Mr. Obey: Please update the information provided on page 122 of Part 7 of the Hearings on the FY 2008 President's request by providing a table including annual ED contract obligations from fiscal years 2000 through 2007 by operating division, and for the Department as a whole. In addition, please include an explanation for the fluctuating reliance on outside contractors.

Secretary Spellings: In fiscal year 2007, the Department spent approximately \$1.446 billion on outside contracts. Since 2000, the Department has seen growth in both its mission and budget. At the same time, the Department's staffing level in terms of full-time equivalent (FTE) positions has been declining. As shown below, since 2000, total procurement obligations as a percentage of total budget appropriation has remained relatively constant at 1.4 – 2.5 percent. Based on the information provided below in the response to your question, the Department does not believe that there has been a rapid growth in its reliance on outside contractors.

ANNUAL ED CONTRACT OBLIGATIONS FOR FY 2000-2007 (in whole dollars)									
Operating Division	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	
Chief Financial Officer	\$43,076,654	\$42,742,561	\$29,997,581	\$34,832,553	\$29,951,942	\$29,861,115	\$32,755,562	\$28,663,832	
Chief Information Officer	19,264,527	45,793,623	52,022,990	26,979,099	62,587,897	73,010,697	45,460,557	60,611,555	
Communications & Outreach						2,342,503	3,834,973	2,840,499	
Deputy Secretary	194,119	117,524	55,332	4,741,632	3,021,766	5,219,398	842,005	1,020,182	
Elementary & Secondary Education	35,844,189	41,280,891	36,037,824	51,182,430	53,586,985	59,148,260	68,317,492	47,603,520	
English Language Acquisition	4,884,700	3,334,681	2,127,822	2,184,803	2,079,538	2,085,147	2,123,238	2,065,838	
Federal Student Aid (excluding Collection Agencies)	272,843,508	346,994,807	448,819,138	494,094,275	445,005,397	434,885,027	499,704,964	532,229,744	
Federal Student Aid (including Collection Agencies)	377,176,226	494,046,400	555,294,982	664,054,810	648,755,190	677,738,328	761,586,308	885,733,820	
General Counsel	211,393	317,013	105,731	104,170	151,331	203,176	295,521	96,239	
Innovation & Improvement				29,215,838	27,242,774	34,684,501	31,231,655	33,151,866	
Inspector General	3,310,171	3,501,348	2,769,788	3,074,988	5,340,033	3,421,387	3,772,028	2,401,776	
Institute of Education Sciences	173,802,189	203,497,726	239,364,372	311,553,152	290,144,861	278,752,577	336,570,571	292,084,426	
Intergovernmental & Interagency Affairs	2,746,784	2,300,133	1,271,391	5,452,186	3,067,876	5,219,852	26,790		
Legislative & Congressional Affairs	31,450	48,013	26,563	34,302	19,884	32,989	41,399	15,832	
Management	10,048,079	11,402,564	13,851,750	38,009,865	15,260,625	29,408,836	21,159,412	19,120,872	
Office for Civil Rights	1,422,751	2,098,760	2,259,738	4,191,640	1,667,915	6,082,769	4,483,849	1,439,582	
Other (Boards, Etc.)	8,848,366	7,455,129	4,662,316	10,829,759	10,414,557	10,683,062	9,743,940	4,304,385	

ANNUAL ED CONTRACT OBLIGATIONS FOR FY 2000-2007 (in whole dollars)								
Operating Division	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Planning, Evaluation, & Policy Development						35,579,327	26,765,100	22,378,962
Postsecondary Education	133,458,542	99,999,757	65,148,646	6,251,041	56,244,358	11,315,931	9,160,626	5,385,485
Safe & Drug Free Schools				5,382,608	3,858,081	12,307,684	9,885,225	11,967,335
Secretary	1,230,167	1,070,829	1,963,437	1,461,462	2,247,331	1,788,584	1,844,995	1,360,060
Special Education & Rehab. Services	36,899,683	35,409,027	21,817,099	35,869,798	42,870,977	47,029,308	22,228,130	16,159,190
Under Secretary	25,172,368	23,589,924	23,302,777	26,484,617	24,888,146	5,020,483	3,874,577	55,608
Vocational & Adult Education	18,695,763	17,826,375	14,154,943	15,735,919	8,825,933	15,197,538	11,898,736	7,893,550
Total Obligations excluding Collection Agencies¹	791,985,402	888,780,684	959,759,238	1,107,666,135	1,088,478,207	1,103,281,051	1,146,021,345	1,092,850,337
Total Obligations including Collection Agencies¹	896,318,120	1,035,832,277	1,066,235,081	1,277,626,670	1,292,228,001	1,346,133,452	1,407,902,689	1,446,354,413
Budget Appropriation²	38,447,366,000	42,061,403,000	56,177,032,000	63,256,811,000	67,212,116,000	71,478,441,000	98,913,606,000	67,382,629,000
Procurement Obligations as a Percent of Budget Appropriation	2.33%	2.46%	1.90%	2.02%	1.92%	1.88%	1.42%	2.15%
FTE	4,593	4,566	4,541	4,479	4,359	4,329	4,153	4,089

¹ Source is U.S. Department of Education financial system (EDCAPS).

² Budget Appropriation includes both mandatory and discretionary dollars.

Note: For more information on U.S. Department of Education contracts, please link to the Department's website: <http://www.ed.gov/about/offices/list/oeof/contracts/contracts.html>.

NON-COMPETED CONTRACT AWARDS

Mr. Obey: Please update and expand the information provided on page 123 of Part 7 of the Hearings on the FY 2008 President's request by providing a table including the number, dollar amount, and percentage of the total for all contracts awarded noncompetitively for each of the fiscal years 2000 through 2007. In addition, please include an explanation for the change in noncompetitive contracts.

Secretary Spellings: Non-competed contracts have ranged from 1.5 percent to about 7.7 percent of total ED contracts over the 8 fiscal years analyzed. Fluctuations result from activity related to contracting with the States, statutes requiring sole source awards, and Federal Student Aid (FSA) modernization activity. For example, the large increases in 2006 and 2007 are due a 3-year sole source contract placement (\$36.7 million in 2006 and \$95.7 million in 2007) to the Common Origination and Disbursement contract, which, since the current origination and disbursement system is contractor-owned, was necessary to continue student aid origination and disbursement services until a Government-owned or licensed system is in production.

Fiscal Year	Total Number of Non-Competed Contracts	Total Dollar Amount of Non-Competed Contracts (In whole \$)	Percentage of Total ED Contract Obligations
2000	28	\$13,554,397	1.51%
2001	39	56,461,446	5.45%
2002	34	30,570,985	2.87%
2003	36	31,219,010	2.44%
2004	80	87,318,162	6.76%
2005	88	39,457,122	2.93%
2006	77	60,049,107	4.27%
2007	66	111,040,704	7.68%

NONCOMPETITIVE CONTRACTS

Mr. Obey: Please update the table on page 43 of Part 7 of the Hearings on the FY 2008 President's request to include the total noncompetitive contract obligations for each operating division within the Department and the share of all such obligations for the Department for each of fiscal years (FY) 2000 through 2007.

Secretary Spellings: We have expanded upon the table on page 43 of Part 7 of the Hearings on the FY 2008 President's Budget Request by providing two tables—the first summarizing noncompetitive contract obligations by operating division for FY 2000-2007 – this table is broken into two displays: FY 2000-2003, and FY 2004-2007, and a second table listing all such noncompetitive contract obligations for FY 2000-2007.

NONCOMPETITIVE CONTRACT OBLIGATIONS BY OPERATING DIVISION -- FY 2000-2003 (In whole dollars)

Operating Division	FY 2000		FY 2001		FY 2002		FY 2003	
	Total Obligations	% of Total Obligations	Total Obligations	% of Total Obligations	Total Obligations	% of Total Obligations	Total Obligations	% of Total Obligations
Chief Financial Officer	\$860,000	6.34%	\$1,236,000	2.19%	\$1,045,791	3.42%	\$788,523	6.89%
Chief Information Officer	2,711,000	20.00%	3,750,000	6.64%	2,260,000	7.39%	2,532,729	4.47%
Deputy Secretary	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Elementary & Secondary Education	0	0.00%	24,130,000	42.74%	4,221,374	13.81%	825,985	2.65%
Federal Student Aid	1,212,000	8.94%	20,429,092	36.18%	8,539,774	27.93%	7,515,658	23.35%
Innovation & Improvement	0	0.00%	0	0.61%	0	0.00%	0	0.00%
Inspector General	915,000	6.75%	0	0.00%	350,000	1.14%	0	0.00%
Institute of Education Sciences	7,575,397	55.89%	5,997,354	10.62%	10,174,046	33.28%	11,289,030	36.16%
Intergovernmental & Interagency Affairs	0	0.00%	344,000	0.00%	135,000	0.44%	0	0.00%
Management	0	0.00%	275,000	0.49%	1,939,000	6.34%	5,269,775	16.88%
Planning, Evaluation, & Policy Development	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Postsecondary Education	131,000	0.97%	300,000	0.53%	790,000	2.58%	810,977	1.60%
Safe & Drug Free Schools	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Secretary	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Special Education & Rehab. Services	150,000	1.11%	0	0.00%	1,116,000	3.65%	1,486,333	5.76%
Under Secretary	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Vocational & Adult Education	0	0.00%	0	0.00%	0	0.00%	700,000	2.24%
Total	\$13,554,397	100.00%	\$56,461,446	100.00%	\$30,570,985	100.00%	\$31,219,010	100.00%

NONCOMPETITIVE CONTRACT OBLIGATIONS BY OPERATING DIVISION -- FY 2004-2007 (In whole dollars)

Operating Division	FY 2004		FY 2005		FY 2006		FY 2007	
	Total Obligations	% of Total Obligations	Total Obligations	% of Total Obligations	Total Obligations	% of Total Obligations	Total Obligations	% of Total Obligations
Chief Financial Officer	\$1,398,873	1.60%	\$1,287,357	3.26%	\$1,220,084	2.03%	0	0.00%
Chief Information Officer	1,700,911	1.95%	1,426,613	0.00%	634,308	0.22%	0	0.00%
Deputy Secretary	682,919	0.78%	1,270,411	3.22%	0	0.00%	0	0.00%
Elementary & Secondary Education	2,210,873	2.53%	300,000	0.76%	473,012	0.79%	0	0.00%
Federal Student Aid	11,780,772	13.49%	14,250,011	36.12%	46,229,587	76.99%	\$102,435,047	92.25%
Innovation & Improvement	25,507,194	29.21%	342,478	0.87%	435,848	0.73%	0	0.00%
Inspector General	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Institute of Education Sciences	29,499,559	33.78%	10,824,084	27.43%	6,407,765	10.67%	5,525,763	4.98%
Intergovernmental & Interagency Affairs	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Management	5,724,866	6.56%	5,961,928	18.73%	2,216,925	4.52%	1,464,407	1.32%
Planning, Evaluation, & Policy Development	0	0.00%	497,017	1.26%	0	0.00%	0	0.00%
Postsecondary Education	420,911	0.48%	1,974,991	5.01%	829,149	1.38%	1,115,486	1.00%
Safe & Drug Free Schools	0	0.00%	572,740	1.45%	583,915	0.97%	0	0.00%
Secretary	391,447	0.45%	0	0.00%	118,523	0.20%	0	0.00%
Special Education & Rehab. Services	6,860,389	7.86%	500,000	1.27%	750,000	1.25%	500,000	0.45%
Under Secretary	989,448	1.13%	0	0.00%	0	0.00%	0	0.00%
Vocational & Adult Education	150,000	0.17%	249,492	0.63%	149,992	0.25%	0	0.00%
Total	\$87,318,162	100.00%	\$39,457,122	100.00%	\$60,049,107	100.00%	\$111,040,704	100.00%

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

			Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
Contract No.	Operating Division	Vendor Name								
ED00PO0956	Chief Financial Officer	ORACLE CORPORATION				659,973				
ED00PO1302	Chief Financial Officer	SENECA CORPORATION		451,000						
ED01CO0032	Chief Financial Officer	THE GEORGE WASHINGTON UNIVERSITY		185,000						
ED01CO0040	Chief Financial Officer	COUNCIL OF CHIEF STATE SCHOOL			621,791					
ED01PO2082	Chief Financial Officer	ECONOMIC SYSTEMS INC		100,000						
ED02PO2554	Chief Financial Officer	DATA SYSTEMS HARDWARE, INC			144,000					
ED03PO0266	Chief Financial Officer	COGNOS CORPORATION				128,550				
ED04CO0011	Chief Financial Officer	COMPUTER SYSTEMS MANAGEMENT INCORPORATED					902,725	300,000	291,000	
ED04PO0709	Chief Financial Officer	CACI, INC. - FEDERAL					105,477			
ED04PO0735	Chief Financial Officer	ORACLE CORPORATION					271,660			
ED04PO2064	Chief Financial Officer	ORACLE CORPORATION					119,012			
ED05CO0013	Chief Financial Officer	E SOURCE TECHNOLOGIES INCORPORATED							444,745	
ED05PO0682	Chief Financial Officer	ORACLE CORPORATION							271,600	
ED05PO0684	Chief Financial Officer	HEWLETT PACKARD COMPANY (3067)							271,013	

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED06PO0339	Chief Financial Officer	HEWLETT PACKARD COMPANY (3067)							332,447	
ED06PO0775	Chief Financial Officer	INTERNATIONAL BUSINESS MACHINES CORPORATION							208,444	
ED06PO0778	Chief Financial Officer	INTERNATIONAL BUSINESS MACHINES CORPORATION							388,192	
ED99PO0593	Chief Financial Officer	LOCKHEED MARTIN GOVERNMENT SERVICES INCORPORATED	550,000		280,000					
HN96015001	Chief Financial Officer	MACRO INTERNATIONAL, INC.	310,000							
SG97027001	Chief Financial Officer	MCFARLAND & ASSOCIATES, INC.		500,000						
ED00CO0005	Chief Information Officer	WASHINGTON CABLE SYSTEMS INCORPORATED	230,000				127,992			
ED00PO3370	Chief Information Officer	PLANETGOV INC	357,000							
ED00PO3509	Chief Information Officer	PLANETGOV INC	230,000							
ED00PO3576	Chief Information Officer	PLANETGOV INC	284,000							
ED00PO4500	Chief Information Officer	PLANETGOV INC	200,000							
ED01CO0059	Chief Information Officer	S R I INTERNATIONAL			180,000					
ED01CO0096	Chief Information Officer	CRITICOM INCORPORATED					368,463	386,810		
ED01CO0097	Chief Information Officer	KARTA TECHNOLOGIES INCORPORATED					191,911			

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED01PO0097	Chief Information Officer	VERIZON WASHINGTON, DC INC			404,000					
ED01PO0640	Chief Information Officer	ASAP SOFTWARE EXPRESS INC			128,000					
ED01PO0772	Chief Information Officer	ELECTRONIC DATA SYSTEMS CORPORATION			624,000	750,739				
ED01PO0810	Chief Information Officer	AT&T CORP				162,000				
ED01PO1916	Chief Information Officer	MICROSOFT CORPORATION		164,000						
ED01PO2842	Chief Information Officer	IMAGITAS, INC		535,000						
ED01PO4182	Chief Information Officer	COMPAQ FEDERAL LIMITED LIABILITY COMPANY			103,000					
ED02PO0864	Chief Information Officer	BOOZ ALLEN & HAMILTON, INC			122,000	1,138,000				
ED02PO1094	Chief Information Officer	INDUS CORPORATION			183,000					
ED02PO1132	Chief Information Officer	SOFTWARE SPECTRUM, INC			114,000					
ED02PO1624	Chief Information Officer	GARTNER, INC.			136,000					
ED02PO1655	Chief Information Officer	CDW GOVERNMENT INC			155,000					
ED02PO1812	Chief Information Officer	ABC RADIO NETWORKS				283,600				
ED03PO1724	Chief Information Officer	MICROSOFT CORPORATION				198,390	194,819			

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED04PO0422	Chief Information Officer	SYPHERLINK INCORPORATED					188,500			
ED04PO0491	Chief Information Officer	SILENT PARTNER SECURITY					424,413	1,039,803	499,308	
ED04PO0639	Chief Information Officer	HEWLETT PACKARD COMPANY (3067)					204,813			
ED06CO0033	Chief Information Officer	BERBEE INFORMATION NETWORKS CORPORATION							135,000	
ED98007076	Chief Information Officer	ALLIED TECHNOLOGY GROUP INC	550,000	1,857,000						
ED98CO0017	Chief Information Officer	AERIC INC.		350,000						
ED98PO3043	Chief Information Officer	GTSI CORP		557,000						
ED99PO2972	Chief Information Officer	BOOZ ALLEN HAMILTON INC	100,000							
MR94126001	Chief Information Officer	CONCEPT AUTOMATION INC OF AMER	480,000							
MR96026101	Chief Information Officer	S B C			111,000					
MR96026101	Chief Information Officer	SOUTHWESTERN BELL TELEPHONE CO	130,000							
MR96026401	Chief Information Officer	VERIZON - WITS 2001 OPERATIONS		287,000						
MR96026501	Chief Information Officer	A T & T CORP	150,000							
ED04CO0154	Deputy Secretary	DYNAMIC SYSTEMS TECHNOLOGY INCORPORATED						1,071,740		

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

			Fiscal Year							
Contract No.	Operating Division	Vendor Name	2000	2001	2002	2003	2004	2005	2006	2007
ED04CO0154	Deputy Secretary	DYNAMIC SYSTEMS TECHNOLOGY INCORPORATED					682,919			
ED05CO0063	Deputy Secretary	SYNERGY ENTERPRISES INCORPORATED						198,671		
ED01CO0040/0006	Elementary & Secondary Education	COUNCIL OF CHIEF STATE SCHOOL		315,000			2,210,873			
ED02CO0031	Elementary & Secondary Education	BLUE HILLS HOMES CORPORATION			2,314,000					
ED05CO0064	Elementary & Secondary Education	GRANATO COUNSELING SERVICES INCORPORATED						300,000	300,000	
ED06CO0115	Elementary & Secondary Education	COMMAND DECISIONS SYSTEMS AND SOLUTIONS INCORPORATED							173,012	
ED98CO0061	Elementary & Secondary Education	READING IS FUNDAMENTAL INC		23,000,000						
ED99CO0115	Elementary & Secondary Education	BLUE HILLS HOMES CORPORATION		815,000	1,907,374	825,985				
ED00CO0007	Federal Student Aid	NATIONAL STUDENT CLEARINGHOUSE	702,000				1,500,000			
ED00CO0018	Federal Student Aid	FRIDAY SYSTEMS SERVICES INC		362,000		1,560,000				
ED00CO0092	Federal Student Aid	CRITICOM		1,356,000						
ED00PO3444	Federal Student Aid	WALT DISNEY WORLD CO	154,000							

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED00PO4117	Federal Student Aid	COMPUTER BUSINESS METHODS INC		1,535,092	642,774	992,464	2,804,996	1,097,827		
ED00PO4153	Federal Student Aid	PUBLIC STRATEGIES GROUP INC, T		370,000	3,887,000	635,000				
ED00PO4497	Federal Student Aid	ACCENTURE LLP		206,000						
ED00PO4531	Federal Student Aid	WALT DISNEY WORLD CO	356,000							
ED00PO4806	Federal Student Aid	ACQUISITION SOLUTIONS INC					835,190			
ED01PO1001	Federal Student Aid	DTI ASSOCIATES INC		160,000		1,171,120	1,071,454			
ED01PO1200	Federal Student Aid	WALT DISNEY WORLD CO		138,000						
ED01PO1250	Federal Student Aid	PRICE WATERHOUSE COOPERS				703,515	162,000			
ED01PO4102	Federal Student Aid	ACCENTURE LLP			1,416,000	363,000				
ED01PO4125	Federal Student Aid	COMPUTER BUSINESS METHODS INC		180,000						
ED03CO0012/0003	Federal Student Aid	NCS PEARSON INC					1,691,185			
ED03CO0014/0001	Federal Student Aid	ROH, INCORPORATED					249,600	259,584		
ED03CO0014/0004	Federal Student Aid	ROH, INCORPORATED					174,168			
ED03CO0027	Federal Student Aid	INDUS CORPORATION						850,914		
ED03CO0094	Federal Student Aid	DEVA AND ASSOCIATES PC					1,572,409			
ED03CO0102/0002	Federal Student Aid	ELECTRONIC DATA SYSTEMS CORPORATION						3,308,543		3,537,256

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

			Fiscal Year								
			2000	2001	2002	2003	2004	2005	2006	2007	
Contract No.	Operating Division	Vendor Name									
ED03CO0102/0007	Federal Student Aid	ELECTRONIC DATA SYSTEMS CORPORATION								2,117,482	
ED04CO0013/0003	Federal Student Aid	GRANT THORNTON LLP						253,526			
ED04CO0013/0004	Federal Student Aid	GRANT THORNTON LLP						276,858			
ED04CO0013/0006	Federal Student Aid	GRANT THORNTON LLP						499,448			
ED04CO0013/0007	Federal Student Aid	GRANT THORNTON LLP						296,224			
ED04CO0013/0015	Federal Student Aid	GRANT THORNTON LLP								2,945,968	
ED04CO0130/0011	Federal Student Aid	NCS PEARSON INCORPORATED								647,587	
ED04CO0134/0004	Federal Student Aid	ENDEAVOR SYSTEMS INCORPORATED						170,815			
ED04CO0134/0005	Federal Student Aid	ENDEAVOR SYSTEMS INCORPORATED						222,898	869,000	960,000	
ED04CO0134/0006	Federal Student Aid	ENDEAVOR SYSTEMS INCORPORATED							270,625		
ED04CO0134/0010	Federal Student Aid	ENDEAVOR SYSTEMS INCORPORATED								250,000	
ED04CO0134/0012	Federal Student Aid	ENDEAVOR SYSTEMS INCORPORATED								215,582	
ED04GS0004/0006	Federal Student Aid	LOW + ASSOCIATES INCORPORATED							403,000	500,126	
ED04PO2549	Federal Student Aid	INTERNATIONAL BUSINESS MACHINES CORP (00019494)								598,311	

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED07PO1459	Federal Student Aid	INFORMATION ANALYSIS INCORPORATED								223,340
ED98CO0014	Federal Student Aid	NCS PEARSON, INC			1,194,000	773,559				
ED98GS0002	Federal Student Aid	COMPUTER SCIENCES CORPORATION		498,000						
ED98GS0005	Federal Student Aid	COMPUTER SCIENCES CORPORATION		10,268,000		1,317,000				
ED99GS0005	Federal Student Aid	COMPUTER SCIENCES CORPORATION		3,548,000						
ED99GS0006	Federal Student Aid	COMPUTER SCIENCES CORPORATION		1,808,000						
PM97053001	Federal Student Aid	OUTSOURCING SOLUTIONS INC			1,400,000					
ED03CO0104	Innovation & Improvement	READING IS FUNDAMENTAL INCORPORATED					25,184,529			
ED04CO0135	Innovation & Improvement	WINDWALKER CORPORATION						322,665	342,478	435,848
ED00CO0129	Inspector General	PRICEWATERHOUSECOOPERS LLP	165,000							
ED01PO3682	Inspector General	PEC SOLUTIONS INC			350,000					
ED99CO0128	Inspector General	TWM ASSOCIATES, INC	750,000							
ED00CO0020	Institute of Education Sciences	EDUTECH LIMITED		1,488,000						
ED00CO0021	Institute of Education Sciences	EDUCATION DEVELOPMENT CENTER,	122,000							
ED00CO0040	Institute of Education Sciences	EDUTECH LIMITED		394,000						
ED00CO0046	Institute of Education Sciences	SACRAMENTO COUNTY OFFICE OF ED	831,000							

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.			Operating Division	Vendor Name	Fiscal Year						
					2000	2001	2002	2003	2004	2005	2006
ED00CO0088	Institute of Education Sciences	NATIONAL ACADEMY OF SCIENCES O	200,000								
ED00PO4225	Institute of Education Sciences	COUNCIL OF THE GREAT CITY SCHO	100,000								
ED01CO0013	Institute of Education Sciences	NORTHWEST REGIONAL EDUCATIONAL LABORATORY						4,498,516			
ED01CO0026	Institute of Education Sciences	AMERICAN INSTITUTES FOR RESEAR						318,208			
ED01CO0026/0017	Institute of Education Sciences	AMERICAN INSTITUTES FOR RESEAR						199,844			
ED01CO0048	Institute of Education Sciences	NORTHWEST REGIONAL EDUCATION L					3,700,000				
ED01CO0065	Institute of Education Sciences	EDUCATIONAL SERVICES, INC			508,000						
ED01CO0082	Institute of Education Sciences	WESTAT, INC		236,354							
ED01CO0082	Institute of Education Sciences	WESTAT, INC			2,339,926		163,202				
ED01CO0082/0009	Institute of Education Sciences	WESTAT, INC						274,484			
ED01CO0082/0011	Institute of Education Sciences	WESTAT, INC						1,996,013			
ED01CO0089/0001	Institute of Education Sciences	CHILD TRENDS							553,291		
ED01CO0100	Institute of Education Sciences	WESTAT, INC		2,451,000	5,944,000		5,991,084	7,325,005			
ED01CO0129	Institute of Education Sciences	WESTED						333,145			
ED01CO0135	Institute of Education Sciences	NATIONAL ACADEMY OF SCIENCES O		125,000							

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

			Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
Contract No.	Operating Division	Vendor Name								
ED01PO2143	Institute of Education Sciences	THE COUNCIL FOR EXCELLENCE IN RESEARCH		143,000	103,000					
ED02CO0018	Institute of Education Sciences	AMERICAN INSTITUTES FOR RESEARCH				224,970				
ED02CO0025	Institute of Education Sciences	INTERNATIONAL ASSOC FOR THE EV				741,000	1,382,456	843,836	1,000,000	925,601
ED02CO0027	Institute of Education Sciences	NONPUBLIC EDUCATIONAL SERVICES			717,120					
ED03CO0030	Institute of Education Sciences	DEPT OF EDUCATION ARIZONA (0000)					156,456	134,585	139,445	139,327
ED03CO0035	Institute of Education Sciences	COLORADO DEPARTMENT OF EDUCATION					177,393	131,825	132,608	136,463
ED03CO0037	Institute of Education Sciences	EDUCATION CONNECTICUT STATE DEPARTMENT OF					238,737	200,323	166,265	157,721
ED03CO0039	Institute of Education Sciences	EDUCATION IDAHO STATE DEPARTMENT OF					159,342	114,568		
ED03CO0040	Institute of Education Sciences	EDUCATION KANSAS DEPT OF						100,631	177,714	147,084
ED03CO0042	Institute of Education Sciences	DEPARTMENT OF EDUCATION MASSACHUSETTS						121,199	131,851	120,514
ED03CO0043	Institute of Education Sciences	EDUCATION MINNESOTA DEPARTMENT OF (7162)						129,917	141,109	137,547
ED03CO0044	Institute of Education Sciences	EDUCATION MISSISSIPPI STATE						154,025	104,290	101,649
ED03CO0045	Institute of Education Sciences	PUBLIC INSTRUCTION MONTANA OFFICE OF					157,931	108,940	107,337	112,961
ED03CO0046	Institute of Education Sciences	EDUCATION NEBRASKA DEPARTMENT OF						112,044	104,070	102,782

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Operating Division			Fiscal Year							
Contract No.	Operating Division	Vendor Name	2000	2001	2002	2003	2004	2005	2006	2007
ED03CO0047	Institute of Education Sciences	EDUCATION NEW JERSEY DEPARTMENT OF						144,317	152,792	155,965
ED03CO0051	Institute of Education Sciences	EDUCATION (265) OKLAHOMA STATE DEPARTMENT OF						126,984	207,498	119,429
ED03CO0052	Institute of Education Sciences	UNRESOLVED VENDOR NAME					184,049	134,786	206,424	131,517
ED03CO0055	Institute of Education Sciences	UTAH STATE OFFICE OF EDUCATION						272,468	196,248	176,080
ED03CO0056	Institute of Education Sciences	EDUCATION VIRGINIA DEPARTMENT OF					172,499	127,422	127,574	125,949
ED03CO0057	Institute of Education Sciences	PUBLIC INSTRUCTION WASHINGTON SUPERINTENDENT OF (1112)						401,815	134,384	134,647
ED03CO0059	Institute of Education Sciences	PUBLIC INSTRUCTION WISCONSIN					190,988	221,684	256,096	136,809
ED03CO0060	Institute of Education Sciences	DEPARTMENT OF EDUCATION WYOMIN					170,867			
ED03CO0061	Institute of Education Sciences	EDUCATION ALABAMA DEPT OF					180,862	129,288	136,209	140,589
ED03CO0062	Institute of Education Sciences	EDUCATION AND EARLY DEVELOPMENT ALASKA DEPARTMENT OF					163,265	115,694	119,595	132,371
ED03CO0064	Institute of Education Sciences	EDUCATION GEORGIA DEPARTMENT OF						140,355		
ED03CO0065	Institute of Education Sciences	EDUCATION HAWAII DEPT OF						164,752		
ED03CO0066	Institute of Education Sciences	ELEMENTARY AND SECONDARY EDUCATION					152,198	110,261	105,995	104,987

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

LISTING OF NON-COMMERCIAL CONTRACTS AWARDED FY 2000-2007 (in whole dollars)			Fiscal Year							
Contract No.	Operating Division	Vendor Name	2000	2001	2002	2003	2004	2005	2006	2007
ED03CO0067	Institute of Education Sciences	EDUCATION NEW HAMPSHIRE DEPAR (0000)					166,503	194,564	125,413	114,817
ED03CO0068	Institute of Education Sciences	NORTH CAROLINA DEPARTMENT OF PUBLIC INSTRUCTION						110,038	104,903	109,335
ED03CO0069	Institute of Education Sciences	PENNSYLVANIA STATE DEPT OF EDU					180,826	212,444	132,752	135,444
ED03CO0070	Institute of Education Sciences	EDUCATION ILLINOIS STATE BOARD OF (2057)						132,074		
ED03CO0071	Institute of Education Sciences	DEPARTMENT OF EDUCATION (0439)							121,146	
ED03CO0072	Institute of Education Sciences	DEPARTMENT OF EDUCATION MAINE					156,566	105,641	104,173	103,158
ED03CO0073	Institute of Education Sciences	EDUCATION MARYLAND DEPARTMENT OF						150,451		104,360
ED03CO0074	Institute of Education Sciences	EDUCATION MICHIGAN DEPARTMENT OF					261,659	133,864	146,653	150,985
ED03CO0075	Institute of Education Sciences	EDUCATION NEVADA DEPARTMENT OF						125,224	129,656	105,544
ED03CO0076	Institute of Education Sciences	EDUCATION NEW MEXICO DEPARTMENT OF						129,467	125,023	156,765
ED03CO0077	Institute of Education Sciences	DEPARTMENT OF EDUCATION OHIO (4820)						141,425	141,522	146,056
ED03CO0078	Institute of Education Sciences	EDUCATION OREGON DEPARTMENT OF				100,621		116,492	112,600	149,980
ED03CO0080	Institute of Education Sciences	TEXAS EDUCATION AGENCY (3079)						115,694		
ED03CO0084	Institute of Education Sciences	DEPT OF EDUCATION CALIFORNIA (8051)						138,099	137,626	137,102

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Operating Division			Fiscal Year							
Contract No.	Operating Division	Vendor Name	2000	2001	2002	2003	2004	2005	2006	2007
ED03CO0085	Institute of Education Sciences	WASHINGTON DC PUBLIC SCHOOLS (0000)					170,933	120,117	118,050	108,859
ED03CO0086	Institute of Education Sciences	EDUCATION FLORIDA DEPARTMENT OF (3914)						274,275	115,026	114,846
ED03CO0088	Institute of Education Sciences	EDUCATION IOWA DEPARTMENT OF (4525)						153,369	204,809	152,072
ED03CO0091	Institute of Education Sciences	EDUCATION TENNESSEE DEPARTMENT OF						108,721	108,313	116,471
ED03CO0092	Institute of Education Sciences	DEPT OF EDUCATION VERMONT					254,439	132,395	134,924	181,454
ED04CO0145	Institute of Education Sciences	STICHTING IEA SECRETARIAAT NEDERLAND					502,277	498,196	500,313	
ED05CO0012	Institute of Education Sciences	NATIONAL ACADEMY OF SCIENCES						1,416,177		
ED05CO0026	Institute of Education Sciences	OPTIMAL SOLUTIONS GROUP LIMITED LIABILITY COMPANY						830,278		
ED05CO0051	Institute of Education Sciences	COGENT INTEGRATIONS LIMITED LIABILITY COMPANY						592,716		
ED05PO1043	Institute of Education Sciences	STATE UNIVERSITY OF NEW YORK						147,088		
ED98CO0007	Institute of Education Sciences	ASPEN SYSTEMS CORPORATION					9,220,073			
ED98CO0009	Institute of Education Sciences	STICHTING IEA SECRETARIAAT		500,000						
ED98CO0022	Institute of Education Sciences	LESSON LAB INC	4,923,000			368,153				
ED98CO0053	Institute of Education Sciences	SOUTHERN ILLINOIS UNIVERSITY 1	116,000	560,000	562,000					

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED99CO0072	Institute of Education Sciences	EDUCATION ARIZONA DEPT OF	333,397							
ED99CO0100	Institute of Education Sciences	TRUSTEES OF BOSTON COLLEGE	800,000							
ED99CO0132	Institute of Education Sciences	MANPOWER DEMONSTRATION RESEARC	150,000	100,000						
ED00CO0049	Intergovernmental & Interagency Affairs	THE ASPEN GROUP INC		200,000	135,000					
ED01CO0019	Intergovernmental & Interagency Affairs	MEDIA ARTS, INC		144,000						
ED01PO0461	Management	VISTRONIX INC				370,816				
ED01PO1114	Management	SILENT PARTNER SECURITY SYSTEM			575,000					
ED02CO0002	Management	HEITECH SERVICES, INC.			696,472					
ED02CO0004	Management	CAMBRIDGE ADVISORS LIMITED LIABILITY COMPANY				381,534	199,363	202,404		
ED02CO0013	Management	ALLSTATE PROFESSIONAL MOVERS,			1,093,000					
ED02PO2631	Management	BOOZ ALLEN HAMILTON				594,752				
ED03CO0006	Management	PRECIS CORPORATION				496,865	546,865	546,865		
ED03CO0031	Management	NEW YEAR TECH INCORPORATED				116,315	633,546	551,129		
ED03CO0098	Management	SILENT PARTNER SECURITY SYSTEM				444,096				
ED03PO1832	Management	INTEGRATED COMMUNICATION SOLUT				1,026,311	2,185,299			

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

			Fiscal Year							
Contract No.	Operating Division	Vendor Name	2000	2001	2002	2003	2004	2005	2006	2007
ED05DO0078	Safe & Drug Free Schools	VISIONARY INTEGRATION PROFESSIONALS INCORPORATED						572,740	583,915	
ED03PO1725	Secretary	KETCHUM, INC.					391,447			
ED06CO0013	Secretary	RCW COMMUNICATION DESIGN INCORPORATED							118,523	
ED00CO0017	Special Education and Rehab. Services	SRI INTERNATIONAL					4,861,339			
ED00CO0077	Special Education and Rehab. Services	DR STEIN DISABILITY CENTRAL	150,000							
ED00CO0079	Special Education and Rehab. Services	CHERRY ENGINEERING SUPPORT SER				908,767	605,325			
ED01CO0066/0006	Special Education and Rehab. Services	DTI ASSOCIATES INC					588,725			
ED01CO0066/0008	Special Education and Rehab. Services	DTI ASSOCIATES INC					805,000			
ED02CO0008	Special Education and Rehab. Services	CHERRY ENGINEERING SUPPORT SER			1,116,000	577,566				
ED05CO0039	Special Education and Rehab. Services	MASSACHUSETTS INSTITUTE OF TECHNOLOGY (3594)						500,000	500,000	500,000
ED06CO0105	Special Education and Rehab. Services	NATIONAL ACADEMY OF SCIENCES							250,000	
ED01CO0080/0002	Under Secretary	URBAN INSTITUTE					189,448			

LISTING OF NON-COMPETITIVE CONTRACTS AWARDED IN FY 2000-2007 (In whole dollars)

Contract No.	Operating Division	Vendor Name	Fiscal Year							
			2000	2001	2002	2003	2004	2005	2006	2007
ED04CO0152	Under Secretary	MATHEMATICA POLICY RESEARCH INCORPORATED					600,000			
ED04CO0158	Under Secretary	NATIONAL ACADEMY OF SCIENCES					200,000			
ED03CO0101	Vocational & Adult Education	CORD COMMUNICATIONS INCORPORATED					150,000			
ED03DO0023	Vocational & Adult Education	ACADEMY FOR EDUCATIONAL DEV				700,000				
ED05CO0061	Vocational & Adult Education	BARBARA MURDOCK AND ASSOCIATES INCORPORATED						249,492		
ED06CO0127	Vocational & Adult Education	KAUFFMAN AND ASSOCIATES INCORPORATED (0375)							149,992	
Total			13,554,397	56,461,446	30,570,985	31,219,010	87,318,162	39,457,122	60,049,107	111,040,704

**CONTRACT AWARDS MADE WITHOUT OPEN COMPETITION—
FISCAL YEARS 2005-2007**

Mr. Obey: Please update the tables on page 123 of Part 7 of the Hearings on the FY 2008 President's request. Please provide a table with the number of contract actions and total awards for contracts issued with less than full and open competition by operating division, and for the Department as a whole, in each of the fiscal years 2005, 2006, and 2007.

Secretary Spellings: The following table provides all contract awards made without full and open competition in fiscal years 2005-2007.

CONTRACT AWARDS MADE WITHOUT FULL AND OPEN COMPETITION—FY 2005-2007
(In whole dollars)

Operating Division	FY 2005		FY 2006		FY 2007	
	No. of Contract Actions	Total POC Obligations	No. of Contract Actions	Total POC Obligations	No. of Contract Actions	Total POC Obligations
Chief Financial Officer	4	\$1,287,357	4	\$1,220,084	0	0
Chief Information Officer	2	1,426,613	2	634,308	0	0
Deputy Secretary	2	1,270,411	0	0	0	0
Elementary & Secondary Education	1	300,000	2	473,012	0	0
Federal Student Aid	14	14,250,011	18	46,229,587	21	\$102,435,047
Innovation & Improvement	1	342,478	1	435,848	0	0
Inspector General	0	0	0	0	0	0
Institute of Education Sciences	47	10,824,084	37	6,407,765	37	5,525,763
Intergovernmental & Interagency Affairs	0	0	0	0	0	0
Management	11	5,961,928	6	2,216,925	5	1,464,407
Planning, Evaluation, & Policy Development	1	497,017	0	0	0	0
Postsecondary Education	2	1,974,991	3	829,149	2	1,115,486
Safe & Drug Free Schools	1	572,740	1	583,915	0	0
Secretary	0	0	1	118,523	0	0
Special Education & Rehab. Services	1	500,000	2	750,000	1	500,000
Under Secretary	1	0	0	0	0	0
Vocational & Adult Education	0	249,492	1	149,992	0	0
Total	88	\$39,457,122	78	\$60,049,107	66	\$111,040,704

Note: All figures are for contracts issued with less than full and open competition.

CONTRACT FTE

Mr. Obey: Please provide the total number of contract FTE for each operating division and the department as a whole for fiscal years 2005, 2006, and 2007.

Secretary Spellings: The Department does not maintain data related to the number of contract FTE. The Department's preference is for performance-based acquisition where requirements are described in terms of what is to be achieved, rather than how it is to be done. ED focuses on intended results and not process. This approach to contracting provides the Department's contractors with maximum flexibility in proposing a solution, including labor mix. Therefore, ED does not place an emphasis on the number of FTE contractors use to produce desired outcomes. However, the Department estimates that approximately 6,000 contractor employees are supporting the Department's operations at any given time.

UNSOLICITED GRANT AWARDS IN FISCAL YEARS 2005, 2006, AND 2007

Mr. Obey: Please provide the number and amount of all noncompetitive grants awarded by each operating division, and the percentage share of all such grants for the department as a whole, in each of fiscal years 2005, 2006, and 2007, excluding any Congressional earmarks. Please provide a listing of all such grants awarded in fiscal year 2007.

Secretary Spellings: The table below shows the number of new noncompetitive grant awards and the total funding of such awards in fiscal years 2005, 2006, and 2007. The awards listed were all unsolicited grant awards.

Unsolicited proposals are reviewed by external peer reviewers following established procedures. The Institute of Education Sciences announces unsolicited grant opportunities on its website at <http://ies.ed.gov/funding/>.

UNSOLICITED GRANT AWARDS – FY 2005-2007
(In whole dollars)

Office	Award Year					
	2005		2006		2007	
	Funding	Number of Awards	Funding	Number of Awards	Funding	Number of Awards
Institute of Education Sciences	\$839,813	4	\$6,451,654	6	\$3,482,985	9
National Institute for Literacy	0	0	\$494,000	1	0	0
Office of Innovation and Improvement	0	0	\$3,995,412	1	\$10,830,000	2
Office of Safe and Drug-Free Schools	\$992,000	1	\$984,060	1	\$960,685	1
Office of Special Education and Rehabilitative Services					\$503,237	2
Total	\$1,831,813	5	\$11,925,126	9	\$15,776,907	14

The Department made 4,486 new discretionary grant awards in 2005, 3,045 in 2006, and 3,595 in 2007. The unsolicited grant awards were 0.11 percent of the new awards in 2005, 0.30 percent in 2006, and 0.39 percent in 2007.

FY 2007 NEW UNSOLICITED GRANT AWARDS

The 14 new unsolicited awards in 2007, totaling \$15,776,907, were made to the following institutions in the listed amounts:

NEW UNSOLICITED GRANT AWARDS IN 2007 (In whole dollars)		
Office and Program	Grantee	Funding
Institute of Education Sciences: Education Research Unsolicited Research Grants	American Institutes for Research Washington, DC	\$399,883
	Educational Testing Service Princeton, NJ	\$125,390
	Educational Testing Service Princeton, NJ	\$74,934
	Northwestern University Chicago, IL	\$787,612
	Northwestern University Chicago, IL	\$600,000
	University of California Los Angeles, CA	\$398,886
	University of Illinois Chicago, IL	\$5,500
	University of Iowa Iowa City, IA	\$273,844
	University of Michigan Ann Arbor, MI	\$816,936
Office of Innovation and Improvement: Fund for the Improvement of Education	Reach Out and Read, Inc. Charlestown, MA	\$5,900,000
	Teach for America, Inc. New York, NY	\$4,930,000
Office of Safe and Drug-Free Schools and Communities: National Programs	Virginia Polytechnic Institute and State University Blacksburg, VA	\$960,685
Office of Special Education and Rehabilitative Services: Personnel Preparation to Improve Services for Children with Disabilities	Claremont Graduate School Claremont, CA	\$403,765
	Michigan State University East Lansing, MI	\$99,472
Total		\$15,776,907

QUESTIONS FROM ROSA L. DELAURO

NO CHILD LEFT BEHIND FUNDING

Ms. DeLauro: Welcome Secretary Spellings. Thanks for coming before the Subcommittee one last time. Let me begin by simply asking you, how can the Department come before this Committee claiming NCLB its #1 priority when its proposed Budget for these programs would result in a 6-year cumulative shortfall of over \$86 billion dollars?

Secretary Spellings: I think your question reflects a perspective that we in the Administration, as well as many others in the Congress, have never shared: that funding NCLB below the authorized levels established in the No Child Left Behind Act represents a "shortfall." The President, just like the Members of this Committee, must make tough decisions in dividing available resources among the literally thousands of programs created by congressional authorizing committees, and few programs are funded at their authorized levels.

As for our record in funding No Child Left Behind, I think it's only fair to point out that in fiscal years 2005 and 2006, Congress appropriated less than the President requested—more than \$600,000 less, in fact—for Title I Grants to Local Educational Agencies, which is the cornerstone of NCLB and the largest Federal elementary and secondary education program. So to the extent that NCLB funding is less than some believe it should be, it is clear that Congress shares responsibility for that outcome.

At the same time, we in the Administration have never believed that more money is the key to reaching the goals established by NCLB. Instead, we hope that the strong accountability systems created by NCLB lead to better use of the more than \$600 billion that our Nation already spends on elementary and secondary education each year, of which the Federal share is only about 9 percent.

REACHING THE 100 PERCENT PROFICIENCY GOAL

Ms. DeLauro: But if we look at this year's Budget proposal, we see the same familiar pattern. The President's request is asking for only a half percent increase to fund NCLB programs in 2009. In real terms, after accounting for inflation and population growth—a record 50 million students will enroll in our schools in 2009—the Budget falls \$5 billion below the 2003 level. Furthermore, you can go on and on about how NCLB is a success, but that is not what I heard from my superintendents when I met with them—they are ready to scrap the whole thing. Even your Budget indicates that most States "would not meet the goal of 100 percent proficiency by 2013-14 unless the percentage of students achieving at the proficient level increased at a faster rate." How can we do this with the amount of funding you are requesting—\$14.7 billion below the authorized level just in fiscal year 2009, and, I repeat, an \$86 billion shortfall since enactment of the law?

Secretary Spellings: We think the more than 40 percent increase in funding for NCLB programs since 2001 speaks for itself, and as I just mentioned, that percentage might be a little higher if Congress had given the President what he asked for in 2005 and 2006. As for what you are hearing from superintendents in your State, there is no question that most superintendents are struggling to meet the challenging goals established by NCLB, and that many are not getting the job done. But to be honest, President Bush and I are more worried about the achievement of our students, and the competitiveness of our economy, than about the comfort level of school superintendents. There is no question that we will need to work harder and smarter to reach the 100 percent proficiency goal, but I don't think we have any alternative than to keep working at it. We are asking that all kids be on grade level in reading and math by 2014, and I have yet to meet a parent who thinks this is too much to ask of our schools. And I have yet to meet a parent who would volunteer to have their child be the one to be left behind if we lower that expectation.

NO CHILD LEFT BEHIND REAUTHORIZATION

Ms. DeLauro: I see that you are proposing to issue regulations and waivers to advance several NCLB-related initiatives in the absence of a reauthorization. As you know the Chairman of the Committee of jurisdiction has been working very hard to reauthorize NCLB. Why aren't you working with him to move forward with legislation?

Secretary Spellings: The Department has, in fact, worked closely with the Education and Labor Committee (and, in the Senate, with the Health, Education, Labor, and Pensions Committee) on the NCLB reauthorization. Early last year, we released *Building on Results*, our reauthorization blueprint. Subsequently, we prepared specific legislative language for the NCLB programs that we believe should be reauthorized, cleared that language through OMB, and provided it to the authorizing committees. The committees have considered these proposals very seriously in their own deliberations. In addition, the Department has met with authorizing committee staff on numerous occasions and provided technical assistance and comments prior to the House Committee posting, on the web, its reauthorization discussion draft last fall. We continue to work with both the House and Senate authorizing committees on their legislative proposals.

My hope is that the Congress will complete work on the reauthorization this year. We want to continue to work with the committees on a reauthorization that maintains the core principles of No Child Left Behind and builds on the successes that have been achieved under that landmark legislation.

Unfortunately, however, progress on the reauthorization has been very slow. Although they have been working on reauthorization for over a year, neither Committee has even held a markup session, much less brought a bill to the floor. As the process continues, and with the increasing likelihood that it will take more time, I believe there are some things the Department can and should do now, to help students who are in school now. That is why, in December, I announced that the Department would open up the "growth-model pilot" to all eligible States. (We had previously capped the number of

States at ten.) This initiative allows States to use measures of student growth in determining whether schools and districts have made adequate yearly progress (AYP) under Title I and, thus, responds to evidence that the “status model” embedded in the Act may not always be the best vehicle for measuring progress and holding schools and districts accountable.

Further, on March 18, I announced a new initiative under which the Department will allow up to ten States to implement “differentiated accountability” for schools that are identified for improvement. States that are approved to participate in this pilot will receive flexibility to vary the type and intensity of interventions to reflect the differing reasons for which schools are so identified. The States participating in the pilot will be able to provide interventions that are particularly intensive for schools that are the lowest performing or that have been low-performing for several consecutive years, and to take a more nuanced approach with schools that may be just missing the mark. This initiative responds to legitimate concern that the accountability language in NCLB may be insufficiently sensitive to the wide variation in schools that do not make AYP. Both of the authorizing committees are considering how to include differentiated accountability in their reauthorization bills. As they continue with those deliberations, I think it is highly appropriate – will add to those conversations -- if we begin to test the concept on a pilot basis.

During my remaining time in office, I will continue to consider, and will likely announce, additional initiatives that will provide greater flexibility, improve accountability, or make other improvements that can be implemented under current law, including through the use of the waiver authority in the statute. Again, with the reauthorization process taking so long, I think that is the appropriate thing to do.

CARL D. PERKINS CAREER AND TECHNICAL EDUCATION ACT – AMERICAN COMPETITIVENESS

Ms. DeLauro: I am concerned with the Administration’s Budget for enhancing student’s global competitiveness. Just last week, I met with a Chamber of Commerce in my district, and we talked a great deal about the need to focus Federal investment in vocational and technical education. We all agreed that Connecticut’s economic success in the future will ultimately depend on its ability to consistently produce a highly skilled workforce. I suspect it is the same with many other States across the Nation.

And I see that the Administration proposes several new initiatives in this area—including \$95 million for Math Now, and advanced funding for the newly authorized America COMPETES Act, which we enacted last year into law. But my concern is this: the initiatives proposed by the Administration total approximately \$189 million dollars, while at the same time, it proposes to eliminate again all funding for the Carl D. Perkins Career and Technical Education Act— a program funded last year at \$1.3 billion and affecting nearly 8 million students enrolled in vocational and training courses. Clearly it does not add up. Can you help me understand why, with the Administration’s focus on American competitiveness and the increased needed for high-skill employees, would the

Perkins Act, a program that has direct links to the country's economic security, be "zeroed out"?

Secretary Spellings: The Administration believes that targeting funds to programs authorized by the America COMPETES Act and No Child Left Behind represents a better opportunity for successfully preparing American students for the workplace or for pursuing postsecondary education than the programs authorized by the Carl D. Perkins Act. The most recent evaluation of the Federal career and technical education program, the 2004 National Assessment of Vocational Education (NAVE), raised questions about its effectiveness in helping to prepare secondary school students academically for the transition to postsecondary education and the workforce. A 2005 survey, conducted by Achieve, Inc., found that employers, colleges, and students themselves think many students graduate from high school without needed skills. The surveyed employers estimated that 41 percent of high school graduates were not sufficiently prepared in mathematics and 38 percent were not sufficiently prepared in writing. In addition, many high school graduates who enroll in postsecondary education are not ready for college-level work. In 2007, Achieve, Inc. reported an increase in the number of States that have joined its American Diploma Project (ADP) Network to work on closing the gap between expectations students are held to in high schools and those they will encounter in the workplace and in postsecondary education. The Administration's Budget proposal requests funds for programs that would help improve education for all students and help them graduate with the academic skills they need to succeed after high school, rather than funding programs such as those under the Perkins Act, which have been unable to demonstrate effectiveness and are narrowly focused.

CARL D. PERKINS ACT ENHANCEMENTS AND 2009 BUDGET REQUEST

Ms. DeLauro: In 2006, Congress overwhelmingly passed the reauthorization of the Carl D. Perkins Career and Technical Education Act, including new provisions related to enhanced accountability and secondary-postsecondary linkages. How will these enhancements be enacted if the program experiences a cut in funding?

Secretary Spellings: Career and technical education (CTE) is predominantly funded with State and local dollars and will continue without a Federal categorical aid program. The new provisions in the Perkins Act, including those relating to enhanced accountability and secondary-postsecondary education linkages, represent essential features of an effective CTE program, and the presence of Federal funds should not affect States' ability or willingness to include or enhance these features in their CTE programs.

PELL GRANTS FOR KIDS PROGRAM

Ms. DeLauro: Secretary, In your testimony, you mention the proposed Pell Grants for Kids \$300 million voucher program for students attending schools in need of improvement that would allow them to transfer to a private school.

As I understand, your proposal includes a provision that scholarship recipients would be required to take an assessment in each grade and subject as required under No Child Left Behind's Title I program. I am curious: how would you enforce any accountability for the private schools if the test results show that students are not achieving?

Secretary Spellings: Under the Pell Grants for Kids program, private schools would agree to a set of conditions prior to receiving scholarship funds. They would agree to assess students who receive the scholarships in reading or language arts, mathematics, and science using either State- or nationally-normed assessments and to report results to the State educational agency (SEA). The SEA would, in its annual report cards, be required to include the number of students who received scholarships and the assessment results for those students who used the Pell Grants for Kids scholarships to attend private schools. Taken together, these requirements would provide for a great deal of public accountability for and transparency in the use of Federal funds.

PRIVATE SCHOOL ACCOUNTABILITY UNDER PELL GRANTS FOR KIDS

Ms. DeLauro: What would the consequences be for failure to make adequate yearly progress for these private schools, which do not receive Title I funding?

Secretary Spellings: Private schools are not subject to the same accountability requirements as public schools under NCLB. In enacting the law, Congress correctly recognized that it would not make sense to require SEAs to subject private schools to school improvement, corrective action, and restructuring requirements (as they do with public schools) as SEAs have no governance authority over private schools, because doing so would undermine the whole concept of what it means for a school to be private, and, in the case of religious schools, it would likely raise constitutional issues. Nonetheless, these schools are publicly accountable in that they are likely to lose enrollment if they do not effectively educate their students. The assessment and reporting requirements of the Pell Grants for Kids program would further enhance this public accountability.

Ms. DeLauro: If there are only a few students taking the test at a given private school, how would schools provide the public with the information required under NCLB accountability standards?

Secretary Spellings: Prior to receiving scholarship funds, private schools would agree to a set of conditions, as discussed above, which includes assessment of scholarship students and reporting of assessment results to the SEA. The SEA would, in its annual report cards, include a section for reporting the number of and assessment results for students who receive scholarships to attend private schools under the Pell Grants for Kids program.

**EXPANDING OPTIONS FOR STUDENTS IN CHRONICALLY
UNDERPERFORMING SCHOOLS**

Ms. DeLauro: Let me be clear: the jury is still out on vouchers and their impact on academic achievement. We do know however, that providing additional reading and math assistance to students who are struggling, highly qualified teachers and targeted resources to schools in need of improvement, can make a difference on academic achievement. With that in mind, why has the Department proposed to fund another misguided voucher scheme for \$300 million while only proposing to increase Title I funding by nearly the same amount?

Secretary Spellings: A key goal of the President's 2009 education Budget and NCLB reauthorization proposal is to provide better options for students from low-income families who are trapped in chronically underperforming schools. The Pell Grants for Kids proposal, along with Title I Grants to Local Educational Agencies, Title I School Improvement Grants, and the Charter School program, are core elements of the Department's strategy to serve students from low-income families who are enrolled in those schools while working to turn around schools in restructuring status. Recent data show a steady increase in the number of chronically underperforming schools and demonstrate the need for a new approach. For example, in school year 2006-07, more than 2,300 schools were in Title I restructuring status and more than 1.2 million high school students failed to graduate. The Department projects that these numbers will continue to increase with the number of schools in restructuring more than doubling by school year 2009-10. As we work to turn around these struggling schools, students from low-income families who attend those schools deserve the opportunity to pursue other educational options, including school choice.

While the Department agrees that Title I is the cornerstone of our efforts to improve the quality of education across this country, particularly for low-income and minority students in high-poverty schools, the size and structure of the Title I program limits the impact of additional funding. For example, the \$300 million proposed for the Pell Grants for Kids program represents approximately 2 percent of the funding provided for Title I Grants to Local Educational Agencies, and would have little impact when spread across 14,000 school districts. However, this amount is sufficient to fund a meaningful demonstration of the potential that expanded school choice offers in terms of improving the achievement of students attending chronically low-performing schools.

The Pell Grants for Kids proposal would provide more than 62,000 students from low-income families, who are enrolled in persistently low-performing schools, with the access and financial means to seek a higher-quality education in another school. Given that the current choice options available to students in restructuring schools tend to be so limited, it is appropriate, indeed essential, to make expanded opportunities available, including private schools and out-of-district public schools. Moreover, by providing parents and students with expanded school choice options, we may help to improve not only the academic performance of the students exercising choice but also the performance of schools at risk of losing students.

IMPROVED ACHIEVEMENT AND COMPETITION THROUGH SCHOOL CHOICE PROGRAMS

Ms. DeLauro: Can you demonstrate the same results with vouchers, as we know has been demonstrated through Title I assistance to low-performing schools?

Secretary Spellings: A growing body of research demonstrates that school choice through vouchers and scholarships has produced significant improvement in student achievement. In a review of eight random-assignment studies of five private-school choice programs, education researcher Jay Greene found positive academic effects for students who used vouchers to attend private schools. All but one of these studies found that students who used scholarships to attend private schools made significant academic gains when compared to their peers who remained in public school. Further, some research suggests that participation in school choice programs may improve the graduation rate for low-income students. A recent study of the Milwaukee voucher program by SchoolChoice Wisconsin found that the 2005-06 graduation rate was 53 percent for low-income students attending public school, compared with 64 percent in the voucher-program schools.

In addition to helping improve achievement of participating students, school choice programs introduce competition into the system, which may have a positive effect on traditional public schools in that they must respond to competition by improving performance and becoming more efficient or will risk losing students.

21st CENTURY COMMUNITY LEARNING CENTERS— AFTER SCHOOL PROGRAMS

Ms. DeLauro: You well know of the bi-partisan support for after-school programs and the critical need for it. More than 14 million children go home unsupervised at the end of the school day and after-school services are in tremendous demand from parents and communities all over the country – yet you propose to cut \$300 million from these programs.

I believe, and I know many of my colleagues share in this, that the 21st Century Community Learning Centers – CCLC – model has worked in communities across the country. In making grants, priority is given to programs with multiple partners in their applications. As a result, 21st CCLC has been exceptionally successful in creating diverse public, community and private partnerships between schools, faith-based and community-based organizations, science centers, colleges and universities, museums, libraries, health clinics and other resources. In fact, 1 in 5 to 6 grantees partners with a faith-based organization, and nearly 2 of every 3 grantees partners with a community-based organization. The majority of grantees match their Federal dollars with State, local, and private support.

I am having a hard time wrapping my head around your proposed cut to this valuable program and even more, your proposal to turn it into a voucher program.

Turning this into a voucher program would endanger the very infrastructure that supports these partnerships and leverages these resources. You should know better than that. Why dismantle and destabilize partnerships in communities that are so deserving of this support?

REDESIGNED, RENAMED 21ST CENTURY LEARNING OPPORTUNITIES PROGRAM

Secretary Spellings: The Administration shares your belief that it is important that children have a place to go after school, especially so that children who are struggling to meet academic standards have an opportunity to receive extra academic help to learn the skills they need to succeed. However, though there are sure to be 21st CCLC programs across the Nation that can demonstrate results, available performance data indicate that programs vary widely in their academic outcomes.

As you may know, the evaluation of the program as it operated prior to the No Child Left Behind Act revealed weaknesses in program implementation and outcomes. Children who participated in the program did not show improvements in academic achievement and, although elementary school students who participated in the program were more likely to feel safe after school, they were also more likely to engage in negative behaviors. Although the Department and the States have worked to improve program quality since that time, the Administration is concerned that the program still fails to show significant results.

21ST CENTURY LEARNING OPPORTUNITIES PROGRAM

In response, we are proposing an approach to after-school programs that would give parents greater choice among State-approved academic enrichment centers. Under our proposal, academic enrichment centers would be required to ensure that the activities they provide are aligned with State and local academic standards and have a positive impact on participating students' academic achievement. Although local projects could provide additional activities, such as recreation programs and arts, the primary use of Federal funds would be to support efforts clearly geared toward generating higher academic achievement of disadvantaged students.

By funding scholarships for disadvantaged students, the program would provide direct aid to families seeking extended-learning opportunities for their children. We believe that parents would prefer to have better options for where their children go after school, and the redesigned and renamed 21st Century Learning Opportunities program would give parents more choices.

Finally, the Administration's Budget request for fiscal year 2009 would reduce funding for the program by 26 percent. Although, as you point out, this reduction may result in fewer children being served, the Administration does not believe that, in a tight

budget environment, the inconsistent program results justify continuing funding at the current level. Our Budget would instead direct additional resources to critical programs like Title I, Special Education, Math Now, and Advanced Placement that are more likely to result in improvements in educational outcomes and attainment of the objectives of the No Child Left Behind Act.

QUESTIONS FROM LUCILLE ROYBAL-ALLARD

PELL GRANTS FOR KIDS PROGRAM— PRIVATE SCHOOL ACCOUNTABILITY

Ms. Roybal-Allard: The newly proposed “Pell Grant for Kids” would funnel money away from our public schools and instead give certain students vouchers for a private school education. The Presidents’ Budget proposal states that voucher recipients would still be tested according to NCLB’s Title I requirements. However, I did not see anything in the Budget proposal about whether private schools would be subject to corrective action if test results show that students are not achieving.

How would you ensure that private schools receiving NCLB money are held accountable if their voucher students fail to make adequate yearly progress on statewide tests?

Secretary Spellings: Under the Pell Grants for Kids program, private schools would agree to a set of conditions prior to receiving scholarship funds. They would agree to assess students who receive the scholarships in reading or language arts, mathematics, and science using either State or nationally normed assessments and to report results to the State educational agency (SEA). The SEA would, in its annual report cards, be required to include the number of students, who received scholarships and the assessment results for those students who used the Pell Grants for Kids scholarships to attend private schools.

Private schools are not subject to the same accountability requirements as public schools under NCLB. In enacting the law, Congress correctly recognized that it would not make sense to require SEAs to subject private schools to school improvement, corrective action, and restructuring requirements (as they do with public schools) as SEAs have no governance authority over schools and because doing so would undercut the whole concept of what it means for a school to be private and, in the case of religious schools, would likely raise constitutional issues. Nonetheless, these schools are publicly accountable in that they are likely to lose enrollment if they do not do an effective job educating their students. The assessment and reporting requirements of the Pell Grants for Kids program would further enhance this public accountability.

STUDENTS WITH DISABILITIES

Ms. Roybal-Allard: I want to ask you about the underinvestment in early intervention for children with disabilities. The 2000 National Academy of Sciences report entitled *From Neurons to Neighborhoods* stated that, “Compensating for missed opportunities, such as the failure to detect early difficulties, often requires extensive intervention, if not heroic efforts, later in life.”

In other words, early intervention is a smart investment because it identifies problems early on and reduces later need for Special Education, income support and other

services. Why, then, hasn't the Department requested additional funding for early intervention to provide preschool-age children (ages 0-5) with the support and services they need to grow and learn well?

Please provide the Committee with specific appropriations for IDEA programs from 1986 to date using the column headings listed below.

STUDENTS WITH DISABILITIES

Secretary Spellings: Research has shown that early intervention for children with disabilities can result in important gains in the intellectual, social, motor, and adaptive behavior of infants and toddlers with disabilities. For this reason, the Administration's request maintains funding for the Grants for Infants and Families and Preschool Grants programs at their fiscal year 2008 levels. The Grants for Infants and Families and Preschool Grants programs support the efforts of States to provide services designed to lessen the needs of very young children with disabilities for future or more extensive services and to ensure that they receive the supports and services they need to prepare them to participate in a meaningful manner when they are ready to enter formal education.

We believe the Administration's requests will provide an appropriate level of resources to support activities for young children with disabilities. Funding under Preschool Grants supplements funds provided to States under the Grants to States program, which serves children with disabilities aged 3 through 21, including all children served under the Preschool Grants program. The Administration is requesting \$11.3 billion for the Grants to States program for fiscal year 2009, an increase of over \$337 million above the fiscal year 2008 level.

In addition, young children with disabilities benefit from other early childhood programs funded by the Federal Government, such as Head Start. We believe that the combination of the proposed funding under the Grants for Infants and Families, Preschool Grants, and Grants to States programs and other sources will provide sufficient funds to support State efforts to provide appropriate early intervention, special education, and related services to preschool aged children with disabilities.

The following tables provide the information you request; the actual or estimated FY appropriation for each of FYs 1986-2007, the number of participants, and the Federal share of average-per-participant cost for the Special Education Grants to States program (IDEA, Part B, Section 611), the Preschool Grants program (IDEA, Part B, Section 619), and the Grants for Infants and Toddlers program (IDEA, Part C).

GRANTS TO STATES

<u>Fiscal Year</u>	<u>Children Served</u> (000s)	<u>Appropriation</u> (Millions of \$)	<u>Federal Share Per Child</u> ¹
1986	4,121	\$1,163	\$282
1987	4,167	1,338	321
1988	4,236	1,432	338
1989	4,347	1,475	339
1990	4,419	1,543	349
1991	4,567	1,854	406
1992	4,727	1,976	418
1993	4,896	2,053	419
1994	5,101	2,150	421
1995	5,467	2,323 ²	425
1996	5,629	2,324	413
1997	5,806	3,108	535
1998	5,978	3,808 ³	636
1999	6,133	4,311 ³	701
2000	6,274	4,990 ³	793
2001	6,381	6,340 ³	991
2002	6,483	7,529 ³	1,159
2003	6,611	8,874 ³	1,340
2004	6,723	10,068 ³	1,495
2005	6,820	10,590 ⁵	1,558
2006	6,814	10,583 ⁵	1,551
2007	6,796	10,783 ⁵	1,584
2008	6,796 ⁴	10,948 ⁵	1,609 ⁴
2009	6,796 ⁴	11,285 ⁵	1,658 ⁴

¹ The Federal share per child is calculated from Grants to States funding, excluding amounts available for studies and evaluations or technical assistance as applicable.

² Includes \$82.878 million to offset elimination of the Elementary and Secondary Education Act, Chapter 1 Handicapped program.

³ Includes \$6.7 million in 1998 for studies and evaluations on a comparable basis. Includes \$9.7 million for studies and evaluations in 1999, \$13 million in 2000, and \$16 million in 2001 through 2004.

⁴ Estimate. The estimate for the FY 2009 Appropriation is the President's request.

⁵ Includes \$10 million for technical assistance activities in 2005, and \$15 million in 2006 through 2009.

PRESCHOOL GRANTS PROGRAM

<u>Fiscal Year</u>	<u>Children Served</u> (000s)	<u>Appropriation</u> (Millions of \$)	<u>Federal</u> <u>Share Per Child</u>
1986	261	\$29	\$110
1987	266	180	677 ¹
1988	288	201	698
1989	322	247	767
1990	352	252	715
1991	367	293	798
1992	398	320	804
1993	441	326	739
1994	479	339	709
1995	522	360	689
1996	549	360	656
1997	562	360	642
1998	572	374	654
1999	575	374	651
2000	589	390	662
2001	599	390	652
2002	617	390	632
2003	647	387	599
2004	680	388	571
2005	702	385	548
2006	704	381	546
2007	714	381	533
2008	729 ²	374	513 ²
2009	743 ²	374 ²	503 ²

¹ The Education of the Handicapped Act Amendments of 1986 changed the Preschool Grants program from a grant program that provided an incentive for States to serve children with disabilities aged 3 through 5 to a program that, beginning in fiscal year 1991, required that services be made available to all such children as a condition for receiving funding for children in this age range under the Grants to States program.

² Estimate. The estimate for the FY 2009 Appropriation is the President's request.

GRANTS FOR INFANTS AND FAMILIES

<u>Fiscal Year</u>	<u>Children Served</u> (000s)	<u>Appropriation</u> (Millions of \$)	<u>Federal</u> <u>Share Per Child</u>
1986	0 ¹	0 ¹	0 ¹
1987	--- ²	\$50	---
1988	--- ²	67	---
1989	--- ²	70	---
1990	--- ²	80	---
1991	--- ²	117	---
1992	105	175	\$1,664
1993	143	213	1,487
1994	151	253	1,679
1995	164	316 ³	1,923
1996	174	316	1,812
1997	187	316	1,685
1998	197	350	1,773
1999	187 ⁴	370	1,981
2000	206	375	1,825
2001	231	384	1,662
2002	247	417	1,685
2003	268	434	1,618
2004	272	444	1,631
2005	286	441	1,541
2006	298	436	1,464
2007	305	436	1,433
2008	314 ⁵	436	1,389 ⁵
2009	323 ⁵	436 ⁵	1,349 ⁵

¹ The Grants for Infants and Families program was first authorized as part of the Education of the Handicapped Act Amendments of 1986.

² Data for numbers served prior to 1992 are not reliable due to the voluntary nature of the program, initial problems in instituting a data collection, and duplicate counting of children served under Grants for Infants and Families and the Chapter 1 Handicapped program.

³ Includes \$34 million in funding to offset funds previously appropriated for the Elementary and Secondary Education Act, Chapter 1 Handicapped program, which was terminated in fiscal year 1994.

⁴ The decrease was due to a major overhaul of the data systems and recalculation of the number of infants and toddlers served in one State.

⁵ Estimate. The estimate for the FY 2009 Appropriation is the President's request.

TOTAL IDEA STATE GRANT FUNDS AND TOTAL APPROPRIATION

<u>Fiscal Year</u>	<u>Total State Grant Funds</u> (Millions of \$)	<u>Total IDEA Appropriation</u> ¹ (Millions of \$)
1986	\$1,336 ²	\$1,494
1987	1,718 ²	1,892
1988	1,851 ²	2,020
1989	1,940 ²	2,109
1990	2,020 ²	2,202
1991	2,413 ²	2,616
1992	2,614 ²	2,855
1993	2,718 ²	2,966
1994	2,859 ²	3,109
1995	2,999 ³	3,253
1996	3,000	3,245
1997	3,786	3,973
1998	4,532	4,746
1999	5,055	5,270
2000	5,755	5,972
2001	7,113	7,363
2002	8,336	8,594
2003	9,696	9,957
2004	10,900	11,161
2005	11,415	11,674
2006	11,400	11,653
2007	11,600	11,803
2008	11,757	11,994
2009	12,094 ⁴	12,336 ⁴

¹ Includes formula grants to States and discretionary grant funding for national activities.

² Includes funding for the Elementary and Secondary Education Act (ESEA), Chapter 1 Handicapped program, which was terminated by the Improving America's Schools Act of 1994.

³ In fiscal year 1995, Congress added \$82.878 million to the appropriation for the Grants to States program and \$34 million to the Grants for Infants and Families program to offset elimination of the ESEA Chapter 1 Handicapped program.

⁴ The estimates for FY 2009 are the amounts included in the President's request.

TITLE I STATE VOCATIONAL REHABILITATION

Ms. Roybal-Allard: The Rehabilitation Act requires that funding for the Title I State VR Grants be increased each year according to the Consumer Price Index-Urban (3.5% for FY 2009). The President's Budget proposes the COLA (\$101 million for FY 2009) be eliminated. Given the high unemployment rate of persons with disabilities and the fact that the State-Federal VR program helps nearly a quarter million people with disabilities find jobs each year, why would the Administration cut the COLA?

Secretary Spellings: The Administration's Budget Request includes almost \$2.9 billion to assist States to increase the participation of individuals with disabilities in the workforce. The State Vocational Rehabilitation (VR) Grants program is the only State formula grant program in the Department of Education whose authorizing legislation provides for an annual inflationary increase in its appropriation. Because of this required adjustment, funding for this program increased by \$201.3 million, or 7.6 percent, between FY 2005 and FY 2007, while funding for other major formula grant programs, such as Title I Grants to Local Educational Agencies and Special Education Grants to States, were reduced or remained about the same. In FY 2008, VR State Grants increased by another \$36.9 million. No increase is requested in FY 2009 because the program has benefited from annual increases in prior years and funds are needed in FY 2009 for other high priority programs.

SUPPORTED EMPLOYMENT

Ms. Roybal-Allard: The Supported Employment (SE) program authorized under Title VI of the Rehabilitation Act and funded last year at \$29.0 million helps persons with disabilities who are the most difficult to employ stay in the workforce. This includes persons with mental illness and developmental disabilities. In fact, the Federal Government's Substance Abuse/Mental Health Services Administration considers Supported Employment an evidence-based practice (see <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/>). Given the priority to fund services that are proven effective, especially those for whom employment is most difficult, why did the Administration eliminate this program?

Secretary Spellings: The Administration recognizes that supported employment can be an effective strategy in assisting individuals with the most significant disabilities to obtain competitive employment in integrated settings. However, supported employment is now an integral part of the VR State Grants program, and there is no longer a need for a separate funding stream to ensure the provision of such services.

The SE State Grants program was first authorized under the Rehabilitation Act Amendments of 1986 to provide supplemental grants to assist States to provide training and time-limited post-employment services for individuals with the most significant disabilities. At that time, supported employment was a promising new practice in employing individuals who traditionally would not have achieved employment in the integrated labor market. Initially, many rehabilitation professionals were skeptical about

its feasibility and concerned about the potential costs. As a supplemental source of dedicated funds, the SE State Grants program provided an incentive for State VR agencies to provide supported employment services.

State VR agencies now recognize supported employment as an integral part of the VR program and a viable employment option for individuals with the most significant disabilities. State VR agencies continue to spend Title I funds (including State matching funds) to provide supported employment services for those individuals who require such services to participate in the integrated labor market. Since State VR agencies must give priority to serving individuals with the most significant disabilities, the Department does not expect the number of individuals receiving supported employment services to decline as a result of this Budget proposal. The Department will continue to monitor the number and outcomes of individuals receiving supported employment services.

MIGRANT AND SEASONAL FARMWORKERS PROGRAM

Ms. Roybal-Allard: The Migrant and Seasonal Farmworkers Program makes comprehensive vocational rehabilitation (VR) services available to migrant or seasonal farm workers with disabilities. Projects also develop innovative methods for reaching and serving this population. Emphasis is given in these projects to outreach, specialized bilingual rehabilitation counseling and coordination of services with other services from other sources. The goal of this program is to increase employment opportunities for migrant or seasonal farm workers who have disabilities. Last year Congress funded this program at \$2.3 million. Given the unique challenges these workers face, why would the Administration eliminate this program?

Secretary Spellings: The Administration recognizes that specialized services, such as those provided through the Migrant and Seasonal Farmworkers (MSFW) program, can be beneficial in meeting the complex needs of migrant or seasonal farmworkers with disabilities. The Department of Education's Budget for fiscal year 2009 eliminates funding for this small, categorical program because all services provided under the MSFW program can be and are provided by the larger Vocational Rehabilitation (VR) State grants program, for which almost \$2.9 billion is requested. The VR State Grants program is the primary vehicle for assisting individuals with disabilities to obtain employment. The specialized services provided under the MSFW program are activities all State VR agencies should be conducting to reach and appropriately serve underserved populations and should not depend on the availability of separate funding. In addition, all States must provide the Department with a description of the strategies they will use to conduct outreach and address the needs of individuals with disabilities who are minorities and individuals with disabilities who have been unserved or underserved by the VR program. If Congress were to eliminate this program, the Rehabilitation Services Administration would ensure that its monitoring efforts include an appropriate focus on State efforts to meet the needs of this population.

PROJECTS WITH INDUSTRY

Ms. Roybal-Allard: Businesses must play a key role in helping employ people with disabilities. The Projects with Industry (PWI) program creates and expands job and career opportunities for individuals with disabilities in the competitive labor market by engaging the participation of business and industry in the rehabilitation process. Last year Congress funded this program at \$19.54 million. Given the need to reach out to businesses isn't this exactly the kind of partnership we need to build better career opportunities for persons with disabilities?

Secretary Spellings: The request reflects the Administration's effort to streamline job training programs and eliminate duplicative and overlapping programs. PWI and the much larger VR State Grants program serve the same target populations. In addition, the services provided by the PWI program may be provided by the larger VR State Grants program. In fact, many of the individuals served by PWI grantees also receive services under the VR State Grants program.

Today, the business community is routinely involved in job training and employment programs. In 1998, the Workforce Investment Act (WIA) was enacted with the purpose of consolidating, coordinating, and improving employment, training, literacy, and vocational rehabilitation programs. Recognizing the importance of involving the business sector in job training and employment programs, WIA provided for local workforce investment boards in each State that include business, industry, labor, and other representatives. Two of the major functions of the Business Advisory Councils that PWI projects are required to establish--identification of available jobs within the community and identification of the skills necessary to perform the jobs--are now functions of the local workforce investment board under WIA. The State VR agency is represented on the local board as a partner of WIA's one-stop delivery system. In addition, since 1992, State VR agencies have been required to have four representatives of business, industry, and labor on their State Rehabilitation Councils.

DEPARTMENTAL EFFORTS TO REACH OUT TO BUSINESSES -- BUILDING CARRER OPPORTUNITIES FOR THE INDIVIDUALS WITH DISABILITIES

The Department recognizes the importance of reaching out to employers to build better career opportunities for individuals with disabilities and believes that it is essential to collaborate with employers and link them with qualified job applicants. In FY 2006, the Department initiated a project to engage various business organizations and employers in working more actively with State VR agencies. As a part of the project, the Department recently made available two products for employers. The updated "*Disability Employment 101*" is a comprehensive guide on hiring employees with disabilities that includes information about how to find qualified workers with disabilities, how to put disability and employment research into practice, and how to model what other businesses have done to successfully integrate individuals with disabilities into the workforce. The guide can be accessed at <http://www.ed.gov/about/offices/list/osers/products/employmentguide/index.html>.

A companion to the guide, the *Disability Employment 101 For Your Business*, can be accessed at the following site.

<http://www.ed.gov/about/offices/list/ose/products/employmentguide/eg101-brochure.pdf>. This brochure targets small- and medium-sized businesses that may or may not have thought of hiring employees with disabilities.

The Department is also supporting regional VR/employer forums with the involvement of business organizations and will be developing a “Forum Highlights” DVD for VR agencies to use with VR counselors and employers.

THURSDAY, FEBRUARY 28, 2008.

**REDUCING THE DISABILITY BACKLOG AT THE SOCIAL
SECURITY ADMINISTRATION/FY 2009 BUDGET OVER-
VIEW**

WITNESSES

MICHAEL ASTRUE, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

PATRICK O'CARROLL, INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION, OFFICE OF THE INSPECTOR GENERAL

RICHARD E. WARSINSKEY, IMMEDIATE PAST PRESIDENT, NATIONAL COUNSEL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS

MARTY FORD, CO-CHAIR, CONSORTIUM FOR CITIZENS WITH DISABILITIES SOCIAL SECURITY TASK FORCE

RONALD G. BERNOSKI, PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES

INTRODUCTION OF WITNESS

Mr. OBEY. Good morning, everyone. Sorry to be late; we had one of those quaint things called caucuses, and once in a while something is actually accomplished in them.

This morning we are going to be discussing the Social Security Administration and the case backlog that seems to be plaguing that Agency. The backlog, I should stipulate at the beginning, is not the fault of the Agency; it is the fault of the policy makers who have allowed it to develop and continue.

We have been holding a number of hearings in this Subcommittee to not just hear from Administration witnesses about the money it is that they are asking, and not just to hear from people about the cost of providing whatever the Administration is asking. We have also been holding some hearings to try to highlight the cost of not providing funding for a number of activities.

The programs administered by the Social Security Administration touch the lives of every American. Benefits are distributed to almost 60 million people and they are equivalent to approximately 20 percent of Federal spending and 5 percent of the Nation's gross domestic product. And, yet, the waiting times to receive benefits under the disability program are far too long. Americans who have been out of work as a result of their disability for over a year have to wait, on average, another year and seven months to receive the benefits that they are entitled to under the social contract of disability insurance that we have developed in this Country. That can have profound impacts on the families of those affected.

Until this past year, Congress did not provide the appropriations needed to keep SSA funded at adequate levels to ensure that the benefits that it receives are administered in a timely fashion. In fiscal year 2008, for the first time since 1992, over 15 years, we

provided the SSA with the President's funding request. In fact, we provided \$150 million more.

For fiscal year 2009, the Administration proposes an additional \$582 million. Even with these additional resources, it is my understanding that the average processing time for disability hearing decisions in fiscal year 2009 will decline by only 29 days, from 535 to 506 days, nearly 17 months. In fiscal year 2000, the processing time was approximately 300 days.

At the end of the fiscal year, over 680,000 hearings will be pending and will take another five years, until 2013, before the backlog is reduced to the 400,000 level that I understand SSA deems optimal.

Services to the public that have been declining will, at best, be maintained at already reduced levels. Since the beginning of fiscal year 2006, 17 field offices have closed and merged, and services to the public have suffered from the combined impact of staffing reductions and lack of funding for overtime.

There is a lot more that I could say. I just want to make clear we are not here today to talk about who shot John. We are simply here to talk about what the problem is, what the nature of the problem is, how adequate the resources are that are being proposed to deal with it, and what resources we would have to provide to actually begin to reduce these backlogs to manageable proportions and, I would hope, eventually come close to eliminating them.

So we are going to hear from the Commissioner today and then, as I understand it, after the first round we will be hearing from a second panel to comment on the situation from the outside.

Before we ask the Commissioner to testify, let me ask Mr. Walsh if he has any comments.

INTRODUCTION OF WITNESS CONTINUED

Mr. WALSH. Thank you very much, Mr. Chairman, for holding this hearing. It is a very important topic that affects tens of millions of Americans.

Welcome, Commissioner Astrue, this morning.

We have before us an issue that affects the health and retirement security of millions of Americans. We have all said before that Social Security is a sacred trust between the Federal Government and our Nation's seniors. That trust must be upheld and continued.

Today there are nearly 57 million Americans receiving Social Security benefits, and with the over-65 population expected to increase nearly 60 percent over the next two decades, myself included, ensuring the solvency of Social Security for future generations must remain at the top of our priority list.

Mr. Commissioner, your budget request appears to be focused on three specific areas: begin to eliminate the disability backlog, increase staff productivity and efficiency, and increase investment technology.

I don't intend to minimize my interest in your testimony, but I, like all my colleagues in the Congress, am very concerned at what has happened with Social Security disability and how quickly it has happened. It is not simply the fact that the backlog has grown to 750,000 cases, which is a very large figure, although I am told

that the actual backlog is closer to 350,000 to 400,000 cases are normally in the system because of the normal ebb and flow of cases.

But I am concerned at what I see when I look at the root of the problem: insufficient or appropriate staffing, grossly disparate productivity across the field in hearing offices, an inefficient and dated technology infrastructure, and apparent institutional problems within each phase of the disability determination process. And with those deficiencies, the Social Security Administration plans to distribute nearly \$110 billion in disability benefits to 9 million beneficiaries. This is a stunning number.

Within those numbers, I am told by staff, \$1 billion from the trust fund will go directly to trial lawyers. I am also told that an average judge adjudicates roughly 500 cases per year. What about judges who consistently perform under that standard? Conversely, what policies are in place to control those judges whose pay rates are considered excessive?

One example that was given to me, a judge who has paid over 8,000 cases in four years. That is a 98 percent pay rate. With an average cost of \$250,000 per claim, that amounts to \$2 billion. Judges that pay too many claims should be held accountable, as well, for the impact of their excessive determinations on the trust fund.

Additionally, you have proposed that part of the problem in resolving the backlog is hiring more administrative law judges. Well, that is great, but if you don't staff them up, how can they do their job? You have judges doing the clerical work and not getting anywhere near the number of cases done. And I am told also that this backlog will not be filled by hiring these additional judges; that there has been so much of a reduction because of retirements and otherwise that this will not really fill the backlog. And the staff hiring that is required is not going to be met for these additional judges.

So there is a lot to cover. I look forward to your testimony and that from the second panel.

And, Mr. Chairman, again, thank you for holding this hearing, and I yield back whatever time I have.

Mr. OBEY. Thank you.

Mr. Commissioner, why don't you proceed to summarize your statement, and we will place the entire statement in the record?

OPENING STATEMENT

Mr. ASTRUE. Thank you, Mr. Chairman. Before I begin, let me say it is an honor to be back before the Subcommittee for the first time in 15 years. I want to express my sincere appreciation to all of you on behalf not only of our employees, but, more importantly, the people we serve, for the efforts that all of you made last year to secure additional funding for the Agency. We greatly appreciate it.

Fiscal year 2008 should be a watershed year for SSA. For the first time in 15 years, as you mentioned, Mr. Chairman, Congress has appropriated not only the President's budget request, but an additional \$148 million to address Social Security's disability back-

log with the plan that we laid out in detail last May before the Senate Finance Committee.

On behalf of the American public, I am very grateful for this support and want to assure you that your decision to support this backlog plan is going to make a big difference in the coming years.

Due to the aging of baby boomers, SSA is now facing an avalanche of retirement and disability claims at the same time that it must address large backlogs due to years of increasing workloads and limited resources. Over the past few years, as Social Security offices lost staff in dramatic fashion, waiting times increased, lines grew longer, and busy rates in our field offices deteriorated. Without sustained adequate funding, the situation will only worsen.

Furthermore, we must reduce the disability backlogs which have dramatically and unacceptably damaged many applicants' lives. It is a moral imperative to reduce these backlogs, which have simply just caused too much heartache for disabled Americans.

With the additional funding provided by Congress, SSA will begin to implement all the key features of our hearing backlog reduction plan. We will build a firm foundation for the future with automation improvements, fast-track reviews, Administrative Law Judge hiring, and other initiatives so that we can significantly reduce waiting times while also improving accuracy.

While fiscal year 2008 will allow us to make significant inroads, sustained adequate funding is critical so that we can continue to make the progress that you wish us to make.

Over the next 10 years, SSA's traditional workloads will increase substantially: retirement claims by over 40 percent and initial disability claims by nearly 10 percent. The first of over 80 million baby boomers has already applied for retirement benefits. Baby boomers are also applying for disability benefits in far greater numbers than previous generations.

At the same time that SSA faces increasing workloads, the Agency must also address non-traditional workloads, such as the Medicare prescription drug program and immigration.

Year after year SSA commits to and achieves annual productivity improvements. Although the budget assumes a 2 percent increase in productivity for 2008 and 2009, as it has for many years, productivity alone cannot offset the increase in our workloads.

Furthermore, inflationary growth and mandatory costs—such as rent, guards, employee salaries, and benefits—have more than offset increases in SSA's budget in recent years, leaving the Agency with even fewer resources to address our critical workloads. SSA currently requires over a \$400 million increase each year simply to keep up with increases in fixed costs.

The 2009 President's Budget will enable SSA to build upon the accomplishments for fiscal year 2008 and continue to make progress. At \$10,460,000,000 for SSA's administrative expenses, the President's Budget provides a nearly \$600 million, or 6 percent, increase over fiscal year 2008. SSA's administrative budget includes \$10,327,000,000 for the Limitation on Administrative Expenses account, \$98 million for the Office of the Inspector General, and \$35 million for research.

OPENING STATEMENT CONTINUED

At this funding level, we expect to make substantial progress with our hearings backlog reduction plan by processing 85,000 more hearings in fiscal year 2009 compared to fiscal year 2008, ultimately reducing the number of hearings pending from over 750,000 to 683,000 in one year. We will be able to reduce the initial disability claim pending level to the lowest level in 10 years, below 500,000 for the first time since 1999.

Finally, the fiscal year 2009 budget will put us in a better position to handle the onslaught of work we are confronting due to the aging of baby boomers. We plan to process over 400,000 additional retirement claims in fiscal year 2009 as compared to fiscal year 2007, enabling SSA to keep up with the influx of baby boomer claims.

SSA's budget provides the necessary resources to begin to halt the decline in customer service by preventing further staffing losses and investing in needed technology. However, SSA will not be able to process all of its less visible work, generally work that is done after an individual is approved for benefits. This budget is a fiscally reasonable and responsible approach, recognizing that the effects of limited resources cannot be undone in one year. A multi-year effort is necessary to eliminate our backlogs and our other issues.

Thank you for this opportunity to present our budget request and to share with you our intentions with regard to the backlog. I ask for your support and welcome any questions you might have.

[The prepared statement and biography of Commissioner Astrue follow:]



COMMITTEE ON APPROPRIATIONS

**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION, AND RELATED AGENCIES**

UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 28, 2008

STATEMENT FOR THE RECORD

**MICHAEL J. ASTRUE
COMMISSIONER
SOCIAL SECURITY ADMINISTRATION**

Mr. Chairman and Members of the Subcommittee, before I begin I want to express my sincere appreciation for your efforts in securing funding for the Social Security Administration (SSA) in Fiscal Year (FY) 2008. FY 2008 could be a watershed year for SSA. For the first time in 15 years, Congress has appropriated not only the President's budget request, but an additional \$148 million to address SSA's disability hearings backlog. On behalf of the American public, I am deeply grateful for the Committee's support of the Social Security programs and want to assure you that your decision to support the Agency and its backlog plan will truly make a difference in people's lives. Today, I will discuss SSA's FY 2009 budget request, as well as our plans to improve the disability workloads.

As you know, SSA is now at a critical juncture. Due to the aging of the baby boomers, SSA is facing an avalanche of retirement and disability claims at the same time that it must address large backlogs due to years of increasing workloads and limited resources. Over the last few years as SSA offices lost staff, waiting times increased, lines grew longer, and busy rates in our field offices deteriorated. Without sustained, adequate funding, this situation will only worsen. Furthermore, we must attack the disability backlogs, which have dramatically and unacceptably damaged many applicants' lives.

It is a moral imperative to reduce the disability backlogs, which have caused an incredible hardship for disabled workers and their families as they cope with the loss of income and often medical insurance as well due to a severe disability. With the additional funding provided by Congress, SSA will be able to implement all of the key features of our Hearings Backlog Reduction Plan. We will build a firm foundation for the future with automation improvements, fast-track reviews, Administrative Law Judge (ALJ) hiring, and other initiatives, so that we can significantly reduce waiting times while also improving accuracy.

While FY 2008 will allow us to make significant inroads, sustained, adequate funding is critical so that we can continue to make progress. Over the next 10 years, SSA's traditional workloads will increase substantially – retirement claims by over 40 percent and initial disability claims by nearly 10 percent. The first of over 80 million baby boomers has already applied for retirement benefits. Baby boomers are also applying for disability benefits in greater numbers than previous generations. At the same time as SSA faces increasing workloads, the Agency must attack the disability backlogs and address new non-traditional workloads, such as the Medicare Prescription Drug Program and immigration reform.

From FY 2001 through FY 2007, SSA achieved a cumulative productivity improvement of 15.5 percent. However, although we continue to be a can-do Agency and are implementing efficiencies both large and small, productivity alone cannot fully offset the increase in our workloads. Furthermore, inflationary growth in costs such as rent, guards, and employee salaries and benefits have more than offset increases in SSA's budget in recent years, leaving SSA with even fewer resources to address these growing workloads. SSA currently requires over a \$400 million increase each year simply to keep up with increases in fixed costs. As a result, staffing levels have declined significantly, which has affected service to the public.

The 2009 President's Budget will enable SSA to build upon planned accomplishments in FY 2008 and make significant progress. At \$10.460 billion for SSA's administrative expenses, the President's Budget provides a nearly \$600 million or 6 percent increase over FY 2008. SSA's administrative budget includes \$10.327 billion for the Limitation on Administrative Expenses account, \$98 million for the Office of the Inspector General, and \$35 million for Research. At this funding level, we expect to make substantial progress with our Hearings Backlog Reduction Plan by processing 85,000 more hearings in FY 2009 compared to FY 2008,

ultimately reducing the number of hearings pending from over 750,000 to 683,000 in one year. We will be able to reduce the initial disability claims backlogs to the lowest level in 10 years; the number of initial disability claims pending will drop below 500,000 for the first time since 1999. Finally, the FY 2009 budget will put us in a better position to handle the onslaught of work we are confronting due to the aging of the baby boomers. We plan to process over 400,000 additional retirement claims in FY 2009 as compared to FY 2007, enabling SSA to keep up with the influx of baby boomer claims.

SSA's budget provides the necessary resources to begin to halt the decline in customer service by preventing further staffing losses and investing in needed technology. The budget is a fiscally reasonable and responsible approach. A multi-year effort is needed to eliminate the disability backlogs. In addition, SSA will not be able to handle some of its less visible work, generally work that is done after an individual is approved for benefits.

Overview of SSA's Programs and Responsibilities

SSA administers the Nation's social security programs, including Old-Age and Survivors Insurance and Disability Insurance (OASDI), commonly referred to as Social Security, and Supplemental Security Income (SSI). Through these programs, SSA affects nearly all Americans at some point in their lives.

In FY 2009, SSA will pay \$683 billion in Federal benefits to nearly 56 million people. While Social Security trust fund benefit payments are permanently appropriated, and therefore not part of the budget requests before this Committee, the administrative resources that SSA needs in order to pay these benefits are part of the appropriations requests that I am asking you to support. SSA has four appropriations requests before this Committee, totaling \$56.3 billion: Limitation on Administrative Expenses, Office of the Inspector General, Supplemental Security Income, and Payments to the Social Security Trust Funds.

In FY 2009, some of the tasks SSA employees will perform with the administrative resources requested in the President's budget include: processing over 6.8 million claims for benefits; making decisions on 644,000 hearings; issuing 20 million new and replacement Social Security cards; processing 274 million earnings items for crediting to workers' earnings records; handling approximately 67 million transactions through SSA's 800-number; issuing 150 million Social Security Statements; processing millions of actions to keep beneficiary and recipient records current and accurate; and conducting 329,000 medical continuing disability reviews (CDRs) and nearly 1.5 million non-disability SSI redeterminations.

In addition to our core workloads described above, SSA has complex responsibilities related to the Medicare program, immigration, homeland security and data exchange programs.

I would now like to discuss our Limitation on Administrative Expenses appropriations request.

President's Request for SSA's Limitation on Administrative Expenses

The President's Budget includes \$10.327 billion for SSA's Limitation on Administrative Expenses (LAE), providing SSA with the resources necessary to administer the Nation's social security programs. This is less than 1.5 percent of SSA's total estimated outlays of approximately \$697 billion under current law, and an increase of \$582 million in discretionary budget authority from the FY 2008 appropriation.

The requested increase is needed to provide the salaries and benefits, facilities, computer and telecommunications equipment, training, and other expenses required to deliver service to the American public. Approximately 70 percent of our administrative resources are used for personnel costs. The remainder is used to support these personnel and the workloads they process. Due to fixed cost increases, such as annual increases to Federal employee salaries, benefits, rent, and guard services, the total requested increase is essential to avoid disruptions to the service SSA provides and to help provide better service to the millions of Americans who count on us each and every day.

There are three overarching themes of SSA's FY 2009 LAE budget:

- **Improving the Disability Programs** - Eliminating the hearings backlog is a moral imperative for the Agency. This effort will take several years, but by the end of FY 2009, SSA will have laid the groundwork of regulatory and process changes needed and will be driving waiting times down. We already have made significant progress, which will be discussed later in the statement. SSA also will process more initial disability claims, resulting in the lowest pending level for these claims since 1999, and will make changes to the disability process to improve timeliness, accuracy and efficiency.
- **Enhancing Service to the American Public** - SSA will continue to improve its retirement and enumeration processes, safeguard personally identifiable information, and reach out to all Americans through financial literacy efforts. Furthermore, with the FY 2008 enacted appropriation and the FY 2009 budget, SSA will end a trend of staffing declines that has damaged service to the public.
- **Innovating, Automating and Investing in the Future** - The FY 2009 budget, if it receives the full support of Congress, will allow SSA to make automation and business process changes which will improve service to the public. The budget also provides more support for program integrity to ensure that the public's money is spent in an appropriate fashion.

I would now like to address these three key areas of SSA's FY 2009 budget in more detail.

Improving the Disability Programs

Eliminating the Hearings Backlog – SSA's Recent Accomplishments and Future Plans

SSA will be implementing the Hearings Backlog Reduction Plan over the next 5 years to eliminate the hearings backlog as efficiently and expeditiously as possible. These new initiatives will increase the Agency's capacity to hold hearings and implement necessary modernizations to the hearing process. Crucial to the plan's success is full funding of SSA's FY 2009 budget, which would ensure that hearing offices have enough staff to handle more cases and allow critical improvements to Agency infrastructure.

There are four key elements of the Hearings Backlog Reduction Plan that I believe hold the most promise to eliminate the hearings backlog:

- Accelerating Review of Cases Likely or Certain to be Approved;
- Improving hearings procedures;
- Increasing adjudicatory capacity; and
- Increasing efficiency through automation and improved business processes.

I am pleased that we have already made progress in many of these areas. For example, national rollout of the Quick Disability Determination (QDD) process, designed to identify and expedite claims that are likely to be allowed, began in October 2007. An electronic screening tool/predictive model is used to identify claims where there is a high probability that the claimant is disabled and where medical evidence can be easily and quickly obtained. QDD claims are electronically routed to the state Disability Determination Services where experienced disability examiners and other staff review and adjudicate them on an expedited basis, many times in less than two weeks. As of January 2008, 1 percent of all cases nationally are being reviewed within 8 days under the new QDD process, and we expect that percentage to increase in the next year.

We also are making progress on Compassionate Allowances, which is a way of quickly identifying diseases and other medical conditions that invariably qualify under SSA's medical listings based on minimal medical information. Many of these claims can be allowed based on confirmation of a medical diagnosis supported by medical evidence. For example, allowances for cases such as catastrophic congenital anomalies (such as anencephaly, a form of Tay-Sachs disease, and the most common form of Down syndrome), acute leukemia, amyotrophic lateral sclerosis (ALS), and pancreatic cancer can be made as soon as the medical diagnosis and onset data is confirmed.

In recent months SSA has continued to significantly reduce the number of hearing requests that have been pending the longest. At the beginning of FY 2007, there were over 63,000 hearing requests that would have been 1,000 or more days old on September 30, 2007. By September 30, SSA reduced that number to 108 and, since then, the remaining cases have been processed. For FY 2008, SSA raised the bar for its own performance and set a goal to resolve over 135,000 cases that are or would be 900 days old or older by the end of the fiscal year. As of the end of January, SSA has reduced that number to 76,099. As the number of aged cases is reduced, SSA will create new targets to ensure we provide decisions to those waiting the longest.

As another key part of the plan, SSA established a National Hearing Center in Falls Church, Virginia so that a centralized cadre of ALJs can use video hearing technology to hear cases from the most backlogged parts of the country. As we review data from the pilot, we will consider opening additional National Hearing Centers to conduct more video hearings and to more effectively balance workloads at hearing offices nationwide.

SSA also is currently implementing a Service Area Realignment Plan to balance hearings backlogs on a national basis. The Service Area Realignment Plan is designed to shift workloads to offices with lower pendings. New requests for hearings may be processed in other offices by means of video hearings.

Another way SSA is expediting hearings is through the Senior Attorney Adjudicator program, which allows Senior Attorneys to issue decisions in cases that are fully favorable without the involvement of an ALJ. Allowing non-ALJs to issue fully favorable on-the-record decisions improves processing times for those hearings and conserves ALJ resources for the more complex cases and cases that require a hearing.

In addition to new rules and processes, a number of electronic initiatives are being developed which would reduce the lengthy procedure to simply prepare cases for the ALJs. For example, the electronic folder has the potential to significantly decrease the time it takes hearing office staff to prepare and exhibit files, associate correspondence, prepare and send notices, and transfer workloads.

Even with all of these improvements, adequate staff is still a critical component of the Hearings Backlog Reduction Plan. Our hearing offices will be able to replace all of their staff losses this year including hiring approximately 150 ALJs this spring, for which we are deeply grateful to Congress. Our goal is to reach a level of 1,250 ALJs in FY 2009. Sufficient funding in FY 2009 and beyond is essential to ensuring that we can maintain an adequate number of ALJs as we continue our efforts to reduce the hearings backlog.

We are pleased to report that hearings processing times and ALJ productivity are already better than we anticipated, resulting in quicker decisions for the American public. While we still have a long way to go to provide the level of service the American public deserves, the progress we have made so far gives me confidence that we are making the right changes in the right places.

Processing More Disability Claims

In FY 2007, SSA was able to stem the tide and slow the growth in the claims backlog. With the FY 2009 budget, the DDSs will process significantly more disability claims, reducing claims backlogs to the lowest level since 1999. This is critical since nearly 70 percent of disability allowances are allowed at the initial claims level. Efforts such as the successful electronic disability process and our new Quick Disability Determination and Compassionate Allowance processes will improve service to the public, helping claimants to receive decisions earlier at this critical juncture in their lives.

I am pleased to report that we have already made significant progress in providing better service to the men and women who serve our country. U.S. military personnel are now receiving expedited processing of disability claims from SSA. We are onsite every week at Walter Reed, Bethesda, Brooke and numerous other treatment facilities throughout the U.S. to take disability cases and ensure expeditious handling of those cases. We also have an agreement with the Department of Veterans Affairs (VA) for the VA to electronically provide SSA with the medical records of veterans applying for disability benefits, which enables SSA to get medical records more quickly and efficiently.

Modernizing the Disability Process

Until just recently, many of SSA's medical regulations—generally known as our "listings"—went decades without review and revision. The Agency is now on a schedule that will review all listings every 5 years, and with this budget SSA plans to review them every 3 years. Moreover, we have an ambitious effort underway to expand the listings to include, for the first time, many rare diseases and conditions. In the past, lack of guidance to adjudicators has resulted in errors in these cases.

Enhancing Service to the American Public

With millions of Americans becoming eligible for Social Security retirement benefits at the rate of 10,000 a day for the next two decades, SSA must continue its development of a wide range of online and automated services and seek to transform its service model. Maximizing the use of modern technology and changing the service delivery model will enable SSA to continue to provide critical services to all future beneficiaries.

In addition, in order to reverse a trend of deteriorating service, SSA also requires an adequate staffing level. The 2009 President's Budget will help SSA begin to turn around the staffing crisis by enabling SSA to replace those employees who leave the Agency, whether for retirement or other reasons. While the stable staffing levels will help SSA improve service on a national level, it will have an even more profound effect on local offices because hiring freezes have caused staffing imbalances and critical staffing shortages.

In addition to preparing for the nation's imminent retirement wave, we have several other priorities. SSA has already opened five Social Security Card Centers, in cities across the country, which have succeeded in issuing cards more efficiently and accurately. To ensure the continued security of the Social Security card and prepare for anticipated growth in card applications if immigration-related legislation is passed by Congress, SSA is planning to open a total of 7 more Card Centers in FYs 2008 and 2009. Our Pasadena, Texas, and Orlando, Florida, Card Centers are expected to open in the spring.

With the prevalence of identity theft in the world today and increased exposure as more transactions are completed across the Internet, our efforts to protect the personal information entrusted to us are more important than ever. SSA's security program includes comprehensive policies and controls to protect the confidentiality, integrity, and availability of data and systems, including personally identifiable information. We closely follow Federal guidelines including security standards and guidelines issued by the National Institute of Standards and Technology (NIST) and the Office of Management and Budget. We have constant monitoring of SSA systems for potential attacks and problems. We limit SSA systems access to a "need-to-know" basis. We have encryption of all data lines across SSA. We also have secure electronic mail solutions between SSA and other Federal agencies where personal information is regularly exchanged.

Finally, SSA must continue to explore new ways to have a greater impact on educating the public about the importance of financial retirement planning. Research indicates that many Americans lack comprehensive financial literacy and often make poor savings and retirement decisions. Improving the public's financial literacy, particularly its understanding about the need for retirement planning and the role of Social Security's retirement benefits as a supplement to other sources of income, could boost personal savings and foster better retirement decisions. Our annual Social Security Statements, online presence, and contacts with the public provide a unique opportunity to participate in educational efforts.

We continue to explore new ways to have a greater impact on educating the public. For example, future plans include a streamlined online claims process and enhanced Internet benefit calculators that will provide real-time estimates of retirement benefits based on the user's earnings record. These tools will facilitate financial planning by allowing multiple "what if" scenarios based on different user-entered retirement dates and earnings amounts.

Innovating, Automating and Investing in the Future

Leveraging Technology

The 2009 President's Budget will allow SSA to continue to invest in the Agency's information technology infrastructure. We are seeking new ways to automate workloads to increase productivity and reduce the impact of the ongoing growth to our workloads. SSA will offer additional services on our website, improve the automated services we offer by telephone, provide more efficient and compassionate service to our disabled clients, and ensure that the sensitive information entrusted to us is protected and can be restored in the case of a disaster.

In FY 2009, some of the new services we will be offering are a much improved claims application package that will help ensure that claimants file for all benefits to which they are entitled, and a more integrated disability application that will streamline the filing process and improve the quality of the data we receive. In addition, we will offer the capability for third parties, such as personnel offices, to help individuals file for retirement benefits.

Improving telephone services also will be a major focus in FY 2009. We will replace our 10 year-old call center network systems, which manage and route our 800-number calls, with a system providing the Agency with 21st century features. In addition, we will continue the replacement of our outdated field office telephone systems with a state-of-the-art phone system that saves the Agency money and provides the capability to review e-mail messages over the phone.

SSA is working with the 54 State DDSs on plans to pursue the replacement, beginning in FY 2009, of the outdated systems that the States use to process disability claims with a modern, web-based case processing system. As soon as we resolve the remaining technical issues of the State DDSs, we plan to proceed.

We will take advantage of the progress that the medical community is making in automating services through Electronic Health Records and Personal Health Records. Using automated exchanges in standardized data formats, medical providers will send us requested evidence electronically, allowing us to compare this information to our updated medical listings and use business intelligence tools to make more accurate, consistent, and timely decisions.

Most importantly, we will continue with the automation of our hearing offices, expanding video conferencing technology to offer attorneys the ability to participate in video hearings from their own offices. Additional functionality that will be provided to the hearing offices includes scheduling software that automates the complex process of scheduling a hearing and case-pulling software that allows us to identify, classify and extract data from document images.

Technology and business process improvements will both play an instrumental role in helping SSA continue to make incremental productivity improvements. From FY 2001 through FY 2007, SSA achieved a cumulative 15.5 percent productivity increase. With the FY 2008 appropriation and the FY 2009 President's Budget, we plan to achieve an additional 2 percent productivity increase in each of these years.

Investing in Program Integrity

The budget includes a special funding mechanism that will provide \$240 million for SSA's program integrity efforts, in addition to the \$264 million already included in the base request, for a total of \$504 million. These efforts protect taxpayers' money by reviewing factors that could

affect eligibility for benefits or the payment amount. The two most cost-effective efforts are CDRs and SSI redeterminations.

CDRs are periodic reevaluations of medical eligibility factors for Disability Insurance (DI) and SSI disability recipients and are estimated to yield \$10 in lifetime program savings for every \$1 spent. The additional funding requested for SSI redeterminations, which are periodic reviews of non-medical factors of SSI eligibility such as income and resources, are estimated to yield \$7 in lifetime program savings for every \$1 spent. SSA plans to process 329,000 medical CDRs and nearly 1.5 million SSI redeterminations in FY 2009.

If found to be as cost effective as redeterminations, up to \$40 million may be used for initiatives to improve the disability process and up to \$34 million may be used to expand the Access to Financial Information project, which automates verification of SSI recipients' assets held in banks. In total, SSA estimates this program integrity funding in FY 2009 will result in over \$4 billion in savings over 10 years.

Other FY 2009 Appropriation Requests

I would like to turn now to a brief summary of the other appropriation requests for FY 2009.

Office of the Inspector General (OIG)

\$98.1 million for the OIG – The request for FY 2009 represents a \$6.2 million increase in resources from the FY 2008 appropriation and provides resources needed to restore some of the staffing losses that occurred in FY 2008 due to budget constraints. The OIG will continue efforts to improve the Agency's integrity, efficiency and effectiveness. To that end, the OIG provides invaluable service by directing, conducting and supervising a comprehensive program of audits, evaluations and investigations relating to SSA's programs and operations. The focal point of this effort is protecting the integrity of the Social Security Number (SSN) and the enumeration process. The OIG has also been an invaluable source of advice and data on the Hearings Backlog Reduction Plan.

Supplemental Security Income

\$45.8 billion for the SSI Program – The SSI program ensures a minimum monthly level of income to eligible aged, blind, and disabled individuals. An individual's income, resources, and living arrangements are evaluated to determine the monthly SSI payment. The President's budget reflects \$42.0 billion for Federal benefit payments to approximately 7.3 million aged, blind, and disabled beneficiaries, \$3.149 billion to reimburse the Social Security trust funds for SSI administrative expenses, \$3 million for beneficiary services, and \$35 million to fund extramural research and demonstration projects for FY 2009. The budget also includes \$15.4 billion for Federal benefit payments for the first quarter of FY 2010.

Estimates of current benefits are driven by the number of recipients eligible for monthly payments and the amount of the monthly payments. The FY 2009 request represents almost a \$1.5 billion increase over the FY 2008 enacted level. The majority of this increase results from mandatory increases in Federal benefit payments due to annual cost-of-living adjustments and an increase in SSI recipients.

Payments to the Social Security Trust Funds

\$20.4 million for Payments to the Social Security Trust Funds – This request will reimburse the Social Security trust funds for the costs of certain benefits and administrative expenses which are initially paid from the trust funds but are chargeable to general revenues. The purpose of this account is to put the trust funds in the same financial position in which they would have been had they not borne the cost of these expenses.

Conclusion

With sustained, adequate funding in FY 2009 and beyond, SSA can significantly reduce disability waiting times and backlogs while investing in the infrastructure needed to serve the baby boomers. It is critical that we begin to stabilize staffing levels and make the necessary automation and business process improvements now more than ever. America's retirement wave has officially begun.

SSA has shown that it makes excellent use of the resources it receives. Our accomplishments, in particular our cumulative 15.5 percent increase in productivity from FY 2001 through FY 2007, demonstrate that SSA is an excellent steward of taxpayer dollars. We plan to build upon our recent successes, such as the electronic disability process, by continuing to automate wherever possible. Investments in technology and new business processes will allow SSA to continue achieving incremental productivity improvements.

However, with 1,400 field and hearing offices in cities and towns across the nation, productivity alone is not enough. Service is certain to deteriorate further without an adequate and timely budget for SSA. SSA programs not only have a huge impact on the national economy, infusing billions of dollars into the economy, but a huge impact on millions of individual people's lives: people striving to build economic security, people who overcome tremendous odds to return to the workplace, people who are able to hold their families together with the help of Social Security.

The funding Congress provided to SSA for FY 2008 has made a difference in people's lives. We already have made progress with our Hearings Backlog Reduction Plan. We are reducing backlogs of our oldest cases first because it is simply unacceptable that Americans have to wait so long for a hearing decision. We have created a National Hearing Center and a Service Area Realignment Plan to distribute work more evenly across the nation. We are allowing Senior Attorneys to issue decisions in cases that are fully favorable without the involvement of an ALJ, and we are pursuing a number of electronic initiatives which will reduce the lengthy procedure to prepare cases for the ALJs. New technology and rules, such as QDD and Compassionate Allowances, are helping SSA to allow cases quicker and earlier in the process. Processing times are better than we anticipated, and the ALJs we will be able to hire this spring will place SSA in an even better position next year.

Mr. Chairman, thank you for the opportunity to present SSA's budget. I understand the many difficult choices the Committee will have to make in the near future as you appropriate funding to numerous worthwhile programs, and I appreciate how much you and the Committee did for SSA and the American people last year. Critical to our future success is adequate funding in FY 2009. People in need are counting on us now more than ever. I look forward to continuing to work with you to ensure that SSA receives a timely and adequate budget so that we can provide the level of service they deserve.

SOCIAL SECURITY ADMINISTRATION
Statement by the Commissioner of Social Security
On
Payments to Social Security Trust Funds

The fiscal year (FY) 2009 appropriation request for Payments to Social Security Trust Funds totals \$20,406,000 and covers three general fund payments to the Social Security trust funds.

Reimbursement for Pension Reform Administrative Costs

Included in this request is \$6,400,000 to reimburse the Old-Age and Survivors Insurance (OASI) trust fund for the cost of administering pension reform responsibilities assigned to the Social Security Administration under Public Law 93-406, the Pension Reform Act. The reimbursement is for the cost of furnishing information on deferred vested pension rights to pension plan participants or their survivors.

The request for FY 2009 is the same as the FY 2008 funding level and reflects the ongoing level of effort associated with this work, which flows from reports received from the Internal Revenue Service regarding individuals who have earned vested pension rights. In the event that actual expenses needed to process this workload exceed the amount available for reimbursement through this account in any fiscal year, the trust fund is made whole in the subsequent fiscal year upon enactment of the Payments to Social Security Trust Funds appropriation for that year.

Unnegotiated Checks

Also included in this request is \$14,000,000 to reimburse the OASI and Disability Insurance (DI) trust funds for the value of interest on benefit checks that remain uncashed after 6 months. This payment is authorized by Section 201(m) of the Social Security Act and Section 152 of the Social Security Amendments of 1983 (P.L. 98-21). The request for FY 2009 is the same as the FY 2008 funding level. It supports the expected level of uncashed check activity and represents the estimated interest for unnegotiated OASDI checks.

Social Security checks are negotiable for only 12 months from their date of issue under the provisions of the Competitive Equality Banking Act of 1987 (P.L. 100-86). The face value of these checks is credited directly to the trust funds from the general funds when the checks are canceled. This account reimburses the trust funds for interest lost through the date of crediting at the following points in the check negotiation process: (1) checks that remain uncashed after 6 months; (2) checks that are cashed after 6 months; and (3) checks that are administratively canceled after 12 months.

Special Payments for Certain Uninsured Persons

The request before this Committee includes \$6,000 to reimburse the OASI trust fund for the cost of special benefits paid to certain uninsured persons aged 72 years and over. The benefits are paid mainly to individuals who attained age 72 before 1968 and did not have a chance to work long enough under Social Security to become insured. This payment covers benefits paid in FY 2007. The amount requested also includes reimbursement for related administrative expenses and interest lost to the trust fund.

The population receiving special payments is a closed group of very aged persons, and their number decreases annually. As of September 30, 2007, there was 1 person receiving benefits under this program, as compared to 2 on September 30, 2006.

Coal Industry Retiree Health Benefits

The request before this Committee does not include additional funds to reimburse the OASI trust fund for work carried out under Section 19141 of the Energy Policy Act of 1992 (P.L. 102-486), which established the "Coal Industry Retiree Health Benefit Act of 1992" (CIRHBA). CIRHBA requires the Social Security Administration to search earnings records of certain retired coal miners to determine which mine operators are responsible for payment of their health benefit premiums under the law. The Social Security Administration computes the premiums due based on a formula established in the Act, notifies the affected mine operators, processes appeals from operators who believe that assignments have been made incorrectly, and responds to and participates in litigation resulting from these agency determinations. Additional funds are not requested for FY 2009 because amounts remaining from the \$10,000,000 per year appropriated in FY 1996 and in FY 1997 will continue to be available until expended to reimburse the OASI trust fund.

The Social Security Administration (SSA) has made initial decisions on all of the retired miners covered under these provisions of the 1992 CIRHBA (the Coal Act) and continues to provide requested earnings records and review the appeals made by the assigned coal operators. In addition, SSA has implemented the Coal Act provisions of The Tax Relief and Health Care Act of 2006 (P.L. 109-432) which significantly impacted and restructured the Coal Act. After carefully reviewing the legislation, obtaining legal advice, and assessing how P.L. 109-432 affected existing policies and procedures, SSA complied with the provision that specifically directed the Commissioner to "revoke all assignments to persons other than 1988 agreement operators for purposes of assessing premiums for plan years beginning on or after October 1, 2007."

While SSA has devoted considerable Agency time and resources to comply with P.L. 109-432, it also remains active in one Coal Act case which is pending adjudication in the Federal Court. The case is as follows:

Nicewonder Group, LLC v. Astrue is pending in the United States District Court for the Western District of Virginia. Plaintiffs filed a complaint alleging that they are not related to a former United Mine Workers of America signatory operator and therefore they are not responsible for the premiums of the eight miners that have been assigned to them. SSA has recently responded to this complaint.

SOCIAL SECURITY ADMINISTRATION
Statement by the Commissioner of Social Security
on
Supplemental Security Income

The Supplemental Security Income program (SSI) guarantees a minimum level of income to financially needy individuals who are aged, blind or disabled. The appropriation request for fiscal year (FY) 2009 is \$30,414,000,000, in addition to the \$14,800,000,000 appropriated for the first quarter of FY 2009 in the FY 2008 appropriation, bringing the total to \$45,214,000,000. This includes \$42,027,000,000 for Federal benefits to aged, blind and disabled recipients, \$3,149,000,000 for administrative expenses, \$3,000,000 for beneficiary services, and \$35,000,000 for research and demonstration projects.

In addition to the appropriation request, in FY 2009 SSA is also planning to use \$1,211,000,000 in carryover of unobligated balances for federal benefit payments, \$54,000,000 in carryover for beneficiary services, and \$8,554,000 for research and demonstration projects.

We are also requesting an advance appropriation of \$15,400,000,000 for the first quarter of FY 2010 to ensure that benefits will continue without interruption into the next fiscal year.

Federal Benefit Payments

The SSI appropriation provides funds for direct cash assistance to eligible aged and blind or disabled recipients to help finance their basic needs. An individual's income, resources and living arrangements are evaluated to compute the monthly SSI payment. The maximum monthly Federal Benefit Rate (FBR) is expected to increase from \$637 for an individual and \$956 for a couple in calendar year 2008 to \$653 and \$980 respectively in 2009. The average monthly benefit is expected to increase from \$473 in FY 2008 to \$486 in FY 2009.

The total FY 2009 request for Federal benefit payments is \$42.0 billion. This is an increase of \$1.35 billion from the amount appropriated for Federal benefits in FY 2008. This increase is primarily the result of annual cost-of-living adjustments (COLA) and a projected increase in SSI recipients. The maximum monthly Federal Benefit Rate is increased each January based on increases in the cost-of-living. A COLA of 2.3 percent was effective January 2008 and a 2.5 percent increase is projected for January 2009. The average number of Federal SSI recipients is expected to increase from 7,155,000 in FY 2008 to 7,314,000 in FY 2009, an increase of about 2.2 percent.

These increases are partially offset by the effect of OASDI COLAs on concurrent SSI/OASDI recipients and the use of more carryover prior-year unobligated balances in FY 2009. Because Social Security benefits are counted as income for concurrent recipients (about 36% of SSI recipients) the higher income reduces the SSI benefit payment. SSA expects to use \$1.2 billion in carryover of prior-year unobligated balances for Federal benefit payments in FY 2009, compared to an estimated \$550 million in FY 2008.

Administrative Expenses

The SSI and Social Security programs are administered on an integrated basis for purposes of economy and efficiency. The Social Security Act authorizes SSA to pay for SSI administrative expenses from the Social Security trust funds through the Limitation on Administrative Expenses (LAE) account. This appropriation funds the SSI program's share of administrative expenses incurred through the LAE account. In the event that actual SSI administrative expenses exceed the amount available for reimbursement through this account in any fiscal year, the trust funds are made whole in the subsequent fiscal year upon enactment of the SSI appropriation for that year.

The FY 2009 request for SSI administrative expenses is \$3,149,000,000. This includes \$217 million in cap adjustment funding specifically for program integrity activities such as continuing disability reviews, SSI redeterminations, and asset verification initiatives. This additional funding will allow SSA to process an additional 112,000 continuing disability reviews and 636,000 redeterminations.

These amounts exclude funding made available in the LAE account from State supplementation user fees. State supplementation is mandatory for certain recipients who were on State rolls just prior to the creation of the Federal program in 1974. Otherwise, States are encouraged to supplement the Federal benefit and may elect to have SSA administer their program. States that choose to have SSA administer their program reimburse SSA for the costs of administering the program based on a user fee schedule established by the Social Security Act. The LAE account assumes funding of \$145,000,000 from State supplementation user fees in FY 2009.

Beneficiary Services

This activity funds reimbursements to Vocational Rehabilitation (VR) agencies for rehabilitation services provided to SSI recipients. It also funds payments to Employment Networks authorized under the "Ticket to Work and Work Incentives Improvement Act of 1999" (P.L. 106-170). SSA plans to obligate \$57 million for beneficiary services in FY 2009, mostly funded from prior-year unobligated balances.

The Ticket legislation allows SSI disabled recipients more flexibility in obtaining "return to work" services by providing them with a Ticket to offer an Employment Network of their choice in exchange for VR services, employment services, and other support services. The regulation to implement the Ticket to Work Program was effective January 28, 2002. The Ticket program has been rolled out to all States and U.S. territories since September 2004. In August 2007, SSA published a Notice of Proposed Rule Making to simplify and improve the Ticket to Work program. SSA expects to publish the final regulation in 2008.

Research

Sections 1110 and 1115 of the Social Security Act provide funding authority, including waiver authority for the SSI program where appropriate, for research and demonstration projects. Authority is provided for conducting both broad-based cross-program projects in the Social Security and SSI programs and projects dealing with specific SSI program issues.

Section 1144 of the Social Security Act requires SSA to conduct outreach efforts to identify individuals who may be eligible for payment of the cost of Medicare under the Medicare Savings Program. The passage of the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (P.L. 108-173), expanded the existing cost-sharing outreach requirements of section 1144 to include outreach to beneficiaries who may potentially be eligible for Medicare prescription drug subsidies under Medicare Part D.

The \$35 million request for the FY 2009 extramural research program, along with \$13.4 million in funds carried over from FY 2008, will fund a range of activities, including projects to develop effective rehabilitation and return-to-work strategies, analyze reform proposals to ensure sustainable solvency, maintain and improve basic data about the Social Security and SSI programs and beneficiaries, and provide outreach to potential beneficiaries of the Medicare Savings Program and prescription drug subsidies. Some of the major research efforts are as follows:

Youth Transition Demonstration (YTD)—assists young people with disabilities to transition to the workforce.

The projects focus on youth between the ages of 14 and 25 who receive (or could receive) disability benefits. In addition, five pilot sites have been funded for a year beginning in 2007. In November, 2007, on the basis of a systematic assessment of the pilot operation and advancement of the SSA research agenda, three of these sites were selected to fully implement their YTD projects beginning in 2008. The overarching goal of the YTD is to find ways to enable young people with disabilities to maximize their potential for self-sufficiency. The projects also are testing whether modified SSI rules will encourage YTD participants to work and save for their future. Throughout implementation of YTD, project staff receives technical assistance and training. The YTD project has joint funding with section 234, as appropriate, based on the participation of Title II and Title XVI beneficiaries.

Evaluation of the Ticket to Work—the evaluation will examine participation by both beneficiaries and the new Employment Networks (EN) created by the program. It will also provide feedback to policymakers through periodic reports detailing data collection, findings and recommendations for program modifications.

The findings thus far indicate that the Ticket program has significant potential but that improvements in beneficiary awareness and EN incentives are needed. Survey findings show that many more beneficiaries are interested in employment and working their way off disability benefits than is reflected in Ticket to Work program participation. Most beneficiaries remain unaware of the Ticket to Work program despite various efforts by SSA to publicize the program. Among those who are aware, a small, but significant number, have tried to use their Ticket but have been unable to find an EN to accept it. Participation by ENs has been disappointing and the evaluation indicates that the current payment rules are not providing enough revenue by ENs to cover their costs. SSA initiatives to reduce EN costs have helped but have not significantly affected EN profitability. The proposed changes to the Ticket to Work program

regulations are

designed to address this cost/revenue imbalance and hold promise for reinvigorating the program.

Compassionate Allowance—a new initiative designed to expedite disability determinations for individuals who, often at the time of application, meet SSA's medical criteria for disability. The project intends to reduce SSA's disability hearings backlog by ensuring that such claims are allowed early in the claims process.

Funding of this initiative supports the following activities:

- Interagency Agreements with the National Institutes of Health, including agreements with its individual institutes and grantees.
- Development of an up-to-date, disease-specific medical information data-base specifically designed to be applicable to SSA's disability criteria.
- Investigation of how advances in medical and information systems technologies can be applied to expedite SSA's processing of compassionate allowances.
- Obtaining expert advice from organizations such as the Institute of Medicine or the National Academy of Social Insurance on discrete medical issues pertaining to SSA's medical criteria for determining disability.
- Development of user-friendly tools designed to aid claimants' interactions with SSA's disability claims processes.
- Field testing and implementation of tools designed to improve disability processes.

The Compassionate Allowances initiative is designed to quickly identify diseases and other medical conditions that invariably qualify under the Listing of Impairments based on minimal objective medical information.

Section 1144/1110 Outreach Requirements:

Medicare Buy-in—cost-sharing under the Medicaid program; Medicare Buy-in Outreach, required by section 1144 of the Social Security Act, requires SSA to provide notification to those potentially eligible for the Medicare Savings Program and help with prescription drug expenses under Medicare Part D. In addition, SSA is required to share lists of those potentially eligible with State Medicaid agencies.

Medicare Part D Prescription Drug Outreach—The major objective of these projects is to increase enrollment of eligible low-income individuals into programs which assist Medicare beneficiaries with their out-of-pocket medical expenses, including prescription drugs.

Homeless Outreach—this initiative will help SSA to demonstrate the effectiveness of using skilled medical and social service providers to identify and engage homeless individuals with disabilities as well as assist them with the application process. The service providers began enrolling project participants in September 2004. As of October 2007, Homeless Outreach

Project & Evaluation (HOPE) grantees enrolled 9,054 homeless individuals in to the HOPE project. Of those, 2,976 have been awarded benefits based on disability.

The HOPE initiative is focused on assisting eligible, homeless individuals in applying for SSI and DI benefits. The HOPE projects will help SSA to demonstrate the effectiveness of using skilled medical and social service providers to identify and engage homeless individuals with disabilities as well as assist them with the application process.

In September 2004, SSA awarded an evaluation contract to Westat Inc. The evaluation report was completed in October 2007.

Solvency Research

The research budget supports efforts to assess the economic and distributional effect of proposals for reforming Social Security and keeping it financially sustainable now and in the future. Two key projects are:

- Retirement Income Modeling, which uses econometric and simulation models to provide policymakers with detailed information on the effects of changes in Social Security on individuals and the economy, with projections for years into the future.
- The Retirement Research Consortium, which consists of three multi-disciplinary centers that perform research and evaluation of retirement policies, disseminate results, train young scholars and practitioners, and facilitate the use of SSA administrative data for policy research purposes.

SOCIAL SECURITY ADMINISTRATION
Statement by the Commissioner of Social Security
on
Limitation on Administrative Expenses

The President's fiscal year (FY) 2009 request for the Limitation on Administrative Expenses (LAE) account is \$10.327 billion, an increase of 6 percent or \$582 million over FY 2008. The LAE request, including funding derived from user fees, provides administrative resources for the Old-Age and Survivors Insurance, Disability Insurance (DI), Supplemental Security Income (SSI) programs, Special Benefits for Certain World War II Veterans, the Medicare prescription drug program, and certain other Medicare support functions.

At this funding level, we expect to make significant progress with our Hearings Backlog Reduction Plan by processing 85,000 more hearings in FY 2009 compared to FY 2008, ultimately reducing the number of hearings pending from over 750,000 to 683,000 in one year. We will be able to reduce the initial disability claims backlog to the lowest level in 10 years; the pending level for these claims will drop below 500,000 for the first time since 1999. Finally, the FY 2009 budget will put us in a better position to handle the onslaught of work we are confronting due to the aging of the baby boomers. We plan to process over 400,000 additional retirement claims in FY 2009 as compared to FY 2007, enabling SSA to keep up with the influx of baby boomer claims.

Salaries and Operating Expenses

The LAE budget request includes \$7.844 billion for Federal salaries and operating expenses, including Federal pay raises and benefit increases and rent for SSA offices across the nation. Approximately 70 percent of our administrative resources are used for personnel costs. The remainder is used to support these personnel and the workloads they process. Due to fixed cost increases, such as annual increases to Federal employee salaries, benefits, rent, and guard services, the total requested increase is essential to avoid disruptions to the service SSA provides and to help provide better service to the millions of Americans who count on us each and every day.

SSA relies on a mix of full time equivalents and overtime to achieve its total workyears. This budget supports 62,538 workyears for SSA proper, essentially providing stable staffing and stopping a trend in recent years of declining staffing levels which has affected service to the public. With 1,400 offices in cities and towns across America, it is important that SSA has adequate staffing now and in the future to provide service to a growing number of beneficiaries.

State Disability Determination Services

The LAE budget request includes \$1.946 billion for operating expenses for the State DDSs. This represents a net increase of \$102 million over the FY 2008 level, primarily to fund State pay raises and higher costs for medical evidence. SSA estimates that almost 2.6 million initial disability claims will be processed by the DDSs in FY 2009, nearly 20,000 more cases than in FY 2008 and 70,000 more cases than in FY 2007. Efforts such as the successful electronic disability process and SSA's new Quick Disability Determination and Compassionate Allowance processes will improve service to the public, helping claimants to receive decisions earlier at this critical juncture in their lives.

In addition, SSA will continue its focus on program integrity by conducting periodic continuing disability reviews (CDR). The FY 2009 President's budget includes a proposal to dedicate funding for increasing the number of CDRs conducted.

Information Technology Systems

The LAE budget request includes \$504 million for Information Technology Systems (ITS) in FY 2009. With this funding, SSA will be able to continue to invest in the Agency's information technology infrastructure. We are seeking new ways to automate workloads to increase productivity and reduce the impact of the ongoing growth to our workloads. SSA will offer additional services on our website, improve the automated services we offer by telephone, provide more efficient and compassionate service to our disabled clients, and ensure that the sensitive information entrusted to us is protected and can be restored in the case of a disaster.

Technology and business process improvements will both play an instrumental role in helping SSA continue to make incremental productivity improvements. From FY 2001 through FY 2007, SSA achieved a cumulative 15.5 percent productivity increase. With the FY 2008 appropriation and the FY 2009 President's Budget, we plan to achieve an additional 2 percent productivity increase in each of these years.

Program Integrity Activities

The President has proposed to set caps on net discretionary budget authority and outlays in FY 2009. The FY 2009 President's Budget would allow adjustments to these caps for spending above a base level of funding for several Government-wide program integrity activities, including SSA's CDRs and SSI redeterminations.

In FY 2009, the LAE base request includes a total of \$264 million dedicated for CDRs and SSI non-disability redeterminations. The request specifies that upon enactment of discretionary spending caps, \$240 million of SSA's budget request would not count towards the overall cap on discretionary budget authority. CDRs are the most effective mechanism SSA has for determining whether DI and SSI disability beneficiaries have medically improved or continue to meet the statutory definition of disability. CDRs are a proven, sound investment – yielding \$10 in lifetime program savings for every \$1 spent. SSI redeterminations are periodic reviews of non-medical factors of SSI eligibility. The additional funding requested for redeterminations are estimated to yield \$7 in lifetime program savings for every \$1 spent. SSA plans to process 329,000 medical CDRs and nearly 1.5 million SSI redeterminations in FY 2009. If found to be cost effective as redeterminations, up to \$40 million may be used for initiatives to improve the disability process and up to \$34 million may be used to expand the Access to Financial Information project, which automates verification of SSI recipients assets held in banks. In total, SSA estimates this program integrity funding in FY 2009 will result in over \$4 billion in savings over 10 years.

User Fees

The FY 2009 LAE request includes up to \$145 million in funding from user fees that are paid by States for Federal administration of SSI State supplementation payments. This is \$12 million higher than the FY 2008 level. Funding derived from the user fees helps cover the costs of administering State supplementation payments. The FY 2009 LAE request also includes up to \$1 million in fees for certification of non-attorney representatives, as provided in section 303(c) of the Social Security Protection Act.

Conclusion

SSA's LAE budget provides the necessary resources to begin to halt the decline in customer service by preventing further staffing losses and investing in needed technology. SSA will be able to process substantially more retirement claims, keeping up with an onslaught of work as baby boomers begin to retire, while significantly reducing the disability backlogs.

It is important to note that at less than 1.5 percent of SSA's total outlays, the LAE budget is a fiscally reasonable and responsible approach. A multi-year effort is needed to eliminate the disability backlogs. In addition, SSA will not be able to handle some of its less visible work, generally work that is done after an individual is approved for benefits.

SOCIAL SECURITY ADMINISTRATION
Statement by the Commissioner of Social Security
on
Office of the Inspector General

Background

As part of the Social Security Independence and Program Improvements Act of 1994, SSA was provided with its own statutory Inspector General. As mandated by the Inspector General Act of 1978, as amended, the Office of the Inspector General's (OIG) mission is to protect the integrity of SSA's programs. The OIG is directly responsible for promoting economy, efficiency and effectiveness in SSA programs and detecting and preventing fraud, waste and abuse. This mission is carried out through a nationwide network of audits and investigations. In conducting audits and investigations, the Inspector General works closely with both the Congress and SSA to improve program management.

Budget Request

The fiscal year (FY) 2009 appropriation request for the OIG totals \$98,127,000. This includes \$28,000,000 to be appropriated from general funds and \$70,127,000 to be transferred from the Social Security trust funds. OIG's FY 2009 budget request provides funds for the current operating expenses of its programs, including:

- Almost \$86.8 million for salaries and benefits; and
- Almost \$11.3 million for other operating expenses such as rent, travel, service agreements, investigative equipment, and supplies.

This request is an increase of approximately \$6 million (6.8 percent) compared to the FY 2008 enacted level. This increase covers the costs of payroll increases including Federal pay raises, within-grade increases, benefit rate increases for health benefits, and higher costs for newer employees hired under the Federal Employees' Retirement System (FERS).

The budget request is driven primarily by costs (including salaries, benefits, rent and core services) associated with supporting the staffing levels needed to conduct audits and investigations. The FY 2009 request supports a staffing level of 604 workyears. With the resources included in this request, OIG will continue to support ongoing major initiatives that focus on key areas such as the protection of personally identifiable information, including the protection and integrity of the Social Security number. OIG will also continue to aggressively pursue anti-fraud activities on a variety of fronts. The Cooperative Disability Investigation Program will continue to investigate disability program fraud while other personnel will combat improper OASDI and SSI payments.

Conclusion

FY 2009 will bring new opportunities for the OIG to fulfill its mission, as well as to confront the continuing challenges of assuring integrity in the nation's largest benefit-paying programs. This budget request provides funding to enable the OIG to carry out that mission and to support SSA's efforts to seek efficiencies, avoid erroneous payments, and combat fraud.

Commissioner's Biography



Michael J. Astrue
Commissioner of Social Security

Michael J. Astrue was sworn in as Commissioner of Social Security on February 12, 2007. He will serve a six-year term that expires on January 19, 2013.

As head of the Social Security Administration, Astrue has responsibility for administering the Social Security programs (retirement, survivors and disability), as well as the Supplemental Security Income (SSI) program.

Social Security provides financial protection to more than 160 million workers and their families, and pays over \$600 billion annually in benefits to more than 50 million Americans who receive monthly Social Security retirement, disability or survivors benefits. The SSI program pays monthly benefits to more than 7 million Americans who have little or no resources and who are aged, blind or disabled.

The Social Security Administration is an independent federal agency headquartered in suburban Baltimore with a national workforce of about 60,000 employees in over 1,400 offices nationwide.

Commissioner Astrue has a distinguished history of public service. He is a former employee of the Social Security Administration, having served as Counselor to the Commissioner. He served as General Counsel of the U.S. Department of Health and Human Services and as the Acting Deputy Assistant Secretary of Legislation. Astrue also served briefly as Associate Counsel to the President of the United States during parts of both the Reagan and Bush administrations. Before becoming Commissioner, he also served as a senior executive of several biotechnology companies.

Born in Fort Dix, New Jersey, and a resident of Belmont, Massachusetts, Commissioner Astrue received his bachelor's degree from Yale University and his J.D. from Harvard University. He and his wife Laura have two children.

HEARINGS BACKLOG REDUCTION PLAN

Mr. OBEY. Thank you.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

Let me begin by referring to the document that you posted on your website, Plan to Reduce the Hearings Backlog, et cetera. I am particularly interested in the conclusion, which says the Administration's plan to dramatically reduce the number of hearings pending, and basically you say it is an issue of adequate funding and, two, greater flexibility in utilization of the appropriations.

Is the only way to right this ship by putting more money into this budget?

Mr. ASTRUE. No, Mr. Chairman. In fact, we have to accept that we need to do things significantly differently if we have any hope of dealing with these issues. We have put in a number of reform efforts to improve productivity. We are going to need improved productivity across the board in order to meet the expectations.

ALJ productivity is up. It is a great credit to the ALJ corps. At a time when the number of ALJs has been dropping dramatically, they did increase their productivity from about 2.1 dispositions per day to 2.3. As the number of ALJs has gone down, the backlogs are not worse than we feared they would be a year ago.

One of the things you need to understand about the system right now is that we are running two inadequate support systems. We have an antiquated paper system that we have put a priority on getting rid of. That timetable has been moved up; it should be substantially gone by the end of the year. Our new electronic system is going to be an improvement. However, it still has issues; it still has need for improvement.

I really face three difficulties. One is we had a disability backlog that was increasing at about 75,000 cases a year. If you take out an anomalous year of the Medicare transfer cases, there was an increase of about 75,000 cases a year in total pending. The staffing was going down dramatically. Until the end of last December, during my whole time as Commissioner, we have been on a continuing resolution with contracting resources.

We also had a number of difficulties with the plan that the previous Commissioner implemented to try to deal with issues in disability. A number of things were not only not working, but were actually aggravating the problem. We had to spend most of the first four months figuring out what was working that we could accelerate, instead of following the 10-year rollout plan, and we have done that with some things like Quick Disability Determinations.

We now have computer models at the front end that pull out some of the cases that should be close to automatic, and we are now deciding those cases in eight days. It is about one percent of the cases nationwide now. That is going to increase until next summer and should peak at about three percent of the cases, and then we are going to slowly increase that until we hit the limits of the model. We don't really know what the limit of the model is.

We have historically neglected the rare diseases and conditions. Although no one disease and condition adds up to a lot of the workload, they are a disproportionately high percentage of the cases

that go off track and actually aggravate the backlog, while also creating heartache for people. We are also moving to a system of presumptive disability for those diseases and conditions where we know, by nature of the disease or condition, that the person is never going to be able to work. Then we don't have to go through the rest of the five-step process.

PRODUCTIVITY AND ACCOUNTABILITY OF ADMINISTRATIVE LAW
JUDGES

Mr. WALSH. If I could interrupt, because it is kind of a long answer.

Mr. ASTRUE. Sorry.

Mr. WALSH. It is a complex problem, but this strikes me as very similar to the situation the Veterans Administration has had over the years in the backlog of disability claims, and they implemented a number of different strategies. I think Tiger teams was the term that one or two of the secretaries used.

Would it make sense to restructure the process, beginning with the judges themselves and their staffing requirements, and reordering the workload and division of labor within those—

Mr. ASTRUE. We are looking at those. We don't assume the status quo. One of the things that we are trying to do, for instance, is try to come up with more robust systems at the first level of review that might mean that the second level of review becomes extraneous at some point. But we are not there yet. We are experimenting with Administrative Law Judges actually having their own staff. Part of the problem now in a number of the hearing offices, in my opinion, is that there is no ultimate accountability. I am not allowed, by statute, to discipline for productivity unless there is an absolute extreme case, as part of the legacy of the 1980s.

They also don't manage their own staff, and a lot of the Administrative Law Judges are frustrated by that. The union doesn't believe that it needs to manage its own judges, but ultimately, my view is, if you are going to move these cases—

Mr. WALSH. Say again, the union doesn't—

Mr. ASTRUE. Doesn't believe that the judges should manage their own staff.

Mr. WALSH. Oh.

Mr. ASTRUE. They are testifying later, and you can ask them about that.

Mr. WALSH. Okay.

Mr. ASTRUE. My view is that it is at least a debatable proposition that we could get substantially greater productivity if we ended all the finger-pointing in the hearing offices between the paralegals, the senior attorney advisors, and the ALJs, and simply ran much more on a model that most Federal and State courts run now. We are testing that now. We don't have enough data yet to tell you whether that will be a significant improvement or not.

Mr. WALSH. We are out of time, so I am going to have to cut you off.

Mr. ASTRUE. I apologize for being long-winded, Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

Mr. OBEY. Sure.

ADMINISTRATIVE LAW JUDGE STAFFING

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair, and thank you for having this hearing. It is unfortunate that we are having this hearing, but I can't tell you the frustration I have every week in my congressional office when I sit down and talk to one of my outstanding staff people who spends a lot of time working on this very issue. And I will tell you why it is so important to me. This is what I hear from my constituents when things aren't going right. I will just paraphrase some of their words.

They go broke because they don't have health insurance because Medicaid doesn't begin until 24 months after receiving Social Security benefits and the COBRA only last so long. They can't pay medical bills and they are on disability.

They have had homes foreclosed or started to go through foreclosure because they can't pay the mortgage. They are evicted from apartments. And I have had to intervene and just really explain to people that the Federal Government has taken too long to take care of things. But we have actually had some success with landlords helping us out, but then they are not getting paid either.

Lack of food. More visits to food shelters.

Can't pay for transportation. Sometimes that means they have to let their car go because they can't keep even minimal repairs up on a car.

Get behind in utilities.

Rack up debt on their credit cards trying to make all those other things happen.

Go to family members on a regular basis, depleting their funds as well, having to beg for help.

Their medical problems worsen. Some of them start becoming depressed, which makes their medical problems even worse.

And I have even had a few die while waiting for a decision.

So I appreciate what you said about trying to scale up and that. I don't think it is enough, but I would like to just ask, out of the 150 or so judges that is bantered around, typically, support staff—my understanding—would be three to four?

Mr. ASTRUE. It is actually higher on my watch. I will have to double-check the numbers because it depends a little bit on the time period when you count, but support staff has actually increased on my watch. We got about—

Ms. MCCOLLUM. No, my question was out of the 150 judges that are going to be put on—and as Congressman Walsh put out, some of them are just going to be filling retirements, so you don't need any more staff, because you are really not increasing the number of judges, are you?

Mr. ASTRUE. Actually, we are, very substantially. We made 144 offers. They are staggered; they started this week. I think—

Ms. MCCOLLUM. How many FTE positions and judges are currently not filled?

Mr. ASTRUE. There is no definition of not filled. It depends on whether you count judges actually deciding cases or judges on duty—

Ms. MCCOLLUM. Do you have enough judges?

Mr. ASTRUE. We don't.

Ms. MCCOLLUM. Okay, so how many FTEs are not filled?

Mr. ASTRUE. What we have—

Ms. MCCOLLUM. If you were going to really take care of this backlog and clear it up in a year and a half, how many judges would you need?

Mr. ASTRUE. What we are aiming for and what we have said in previous testimony is for this year we are aiming for 1,175 judges actually deciding cases. That is up from just over 1,000 now.

ADMINISTRATIVE LAW JUDGE STAFFING CONTINUED

Ms. MCCOLLUM. I am trying to get to the bottom line here. How many retirements do you have in the year you are replacing the judges?

Mr. ASTRUE. Let me answer the previous question a little bit. What I testified before is that we think the minimum we need on an ongoing basis—and this might be a little low—is about 1,250. This budget takes us to about 1,175. But that is probably as much as we can absorb and train in one year. The fiscal year 2009 budget would take us up to that 1,250. And although there has been misinformation floating around about inadequate support staff, that is simply not true. The Office of Disability and Adjudicative Review budget under our plans is going over 8,000 this year, for the first time in many years. We hired support staff with the supplemental to the continuing resolution last March—

Ms. MCCOLLUM. What is your retirement rate for your support staff in the next couple of years? Do you know that? Could you get it to us?

Mr. ASTRUE. I will have to supply that for the record.

[The information follows:]

ATTRITION RATE FOR ADMINISTRATIVE LAW JUDGE SUPPORT STAFF

The attrition rate for ALJ support staff was approximately 6 percent in FY 2007.

CHICAGO REGION WAIT TIMES

Ms. MCCOLLUM. Because that is the other thing, as you lose expertise.

Mr. Chair, I am just going to put some numbers into the record here. In the Chicago region, which we are part of: Title 2 Social Security disability, 81.1 days; Title 16, 87.8 days; hearings—this is just Minneapolis recipients—2,302; dispositions, 1,778; pending, 10,335; averaging processing time, 541 days for Minneapolis.

And as I know my time is running out, Mr. Chair, I just want to end with a quote. And I won't mention the constituent's name, I will paraphrase what he shared with me. He has cerebral palsy and diabetes. He had a stroke. He has been unable to work. He has no health coverage and provides a home for his deaf mother. He had to take out early withdrawals from his IRA, incurring a 10 percent penalty because he was not declared disabled by Social Security.

Mr. Chair, I am glad you are having this hearing, and we need to fix this problem. Thank you.

Mr. OBEY. Thank you.

DISABILITY WATERFALL

Dr. Weldon.

Mr. WELDON. Thank you, Mr. Chairman. It is a subject of personal interest that we are discussing today. When I practiced medicine prior to my election, I would get, obviously, involved in a lot of these things and some of them were very clear cut—massive stroke, renal failure—and there would usually be quick determinations.

I just want to clarify a couple things about this backlog. All of the people in the appeal process have had a denial from Social Security Administration staff at the State office levels, correct?

Mr. ASTRUE. Most of them have—

Mr. WELDON. I am talking about people who applied in the obvious cases with a clear disability have gotten their disability determination. So these are for all the people that have been denied the claim that they qualify, correct?

Mr. ASTRUE. Yes. Depending on the State, they have either had one or two denials by the time they get into the Federal system; you are correct.

Mr. WELDON. Okay. Now, the average Administrative Law Judge sees about, I don't know, 600 of these cases a year and—

Mr. ASTRUE. Actually, less than that.

Mr. WELDON. Less than that? And ultimately makes a determination that they qualify for disability in about two-thirds of the cases, is that correct?

Mr. ASTRUE. I think the most recent is about 62 percent of the cases, yes.

Mr. WELDON. Okay. Now, to me, from my perspective, you know, the question I have is—from my perspective, if I am a lawyer advertising on TV for disability claims and you have got a system where two-thirds of the people who get denied, you are going to get them a disability benefit, doesn't that create an incentive for more appeals to the process? I mean, are you looking at that component of it, that we have basically created an industry to appeal these claims?

And as I also understand it, even in front of the Administrative Law Judge, after there is a denial, if there are new developments in a case, typically, the doctor makes a new diagnosis or something like that, there is a second appeal or there can be a third appeal, is that correct?

Mr. ASTRUE. That is substantially correct. There are several key points here. One of the things—and I appreciate the opportunity to clarify—that we get criticism on, but I don't think people are looking at the waterfall correctly, is that we get about 2.5 million applications a year. It is the largest system of justice in the world. We allow, up front, a little under 1 million cases. A little over 1 million people do not appeal.

What you see in the hearings and appeals process is a little over half a million people. That is about 20 percent of the overall cases. They are, by definition, the close calls. The reason the allowance rate has gone up from more of a historic rate of about 50 percent is because the backlog has increased. It is quite reasonable—it is a sign, actually, the system is working the way it is supposed to

that the allowance rate goes up because we have an open-ended system. There is no lock-down as in a traditional legal appeal—

Mr. WELDON. Final denial.

Mr. ASTRUE. Right. A number of the people that we see have diseases or conditions that are progressively debilitating, and they don't qualify up front, but they are in the process for a long time and at some point do. The ALJs are not restricted to the evidence that the State saw, so they are free to say, okay, you are now disabled.

The other thing that happens, too, is there is a face-to-face hearing at the ALJ level. There is often key evidence that is brought out at that hearing that was not available earlier. The claimants are more likely to be represented at that point, which is often helpful to them. In fact, one of the things—

Mr. WELDON. Well, I am not opposed to an appeal process. I am just trying to get a little bit of perspective here, because I get the same kind of cases the gentlelady from Minnesota was talking about coming to my office, where it seems like there should have been a determination. I am just trying to look at the other side of this. Are we feeding a monster, I guess, is what I am trying to say.

Now, I had one other question, because I am going to run out of time too.

Mr. ASTRUE. Okay.

DISCIPLINE OF ADMINISTRATIVE LAW JUDGES

Mr. WELDON. And the gentleman from New York mentioned this. A particular judge who sees, in a community, two or three—who runs through two or three times the number that every other judge does and he has a 98 percent approval rate. So if I am a lawyer advertising on TV to appeal Social Security cases for that jurisdiction, I have got a 98 percent chance. And my question for you is do you have any tools to basically evaluate the judges and discipline the judges? And I think you said this in your opening comments, you really can't do anything.

Mr. ASTRUE. No.

Mr. WELDON. You have to be egregious?

Mr. ASTRUE. Part of the long-term price for the disability wars in the 1980s is that Congress made a decision to tie the Commissioner's hands with regard to those issues in the name of the independence of the ALJs. I think there is an argument that that was an overreaction because—

Mr. WELDON. So there is nothing that you can do to this one particular judge who is running through thousands more cases than other judges and awarding 98 percent of the cases?

Mr. ASTRUE. No. As a practical matter, even for gross misconduct—and we have much more of that than I would like to see—there are special rules for the judges, and they stay on full pay while we pursue cases at the Merit Systems Protection Board, which has a track record of just slapping them on the wrist. We have got some egregious cases of fraud against the government, violence against women, and the judges basically get a paid vacation while we take the case to the MSPB.

We have stood up much more, in my opinion, than any Commissioner in a long, long time to say these things aren't acceptable, but

I would urge you to take a look at that process. I am not allowed to volunteer names and specific examples, but I think you ought to look at that as part of your oversight responsibility and decide whether you are comfortable with judges who have pled guilty to prostitution, who have struck women, who have defrauded the Federal Government by collecting two Federal salaries at the same time.

Again, most of the ALJs are wonderful, well-intentioned people. They are frustrated with our systems and support. I don't blame them. Most of them are trying their best and are good people, but we have bad apples, and they also tend to be the people that are corrosive in the workplace and don't produce cases.

We have judges that do 2,000 cases in a year. We have, I believe, one judge that hasn't done a case in seven years. We had a judge that did 40 last year. If I come up with a proposal unilaterally, I get hit with I am compromising the independence of the judges. I am telling you the facts. I think it is a problem and I would encourage you to take a look at it.

Mr. WELDON. Thank you.

SSA'S ADMINISTRATIVE BUDGET

Mr. OBEY. Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman.

Good morning.

Mr. ASTRUE. Good morning.

Ms. LEE. Let me ask you about your administrative budget.

Mr. ASTRUE. Yes.

Ms. LEE. It is my understanding that about \$100,000,000 will be cut from that. Is that accurate or not?

Mr. ASTRUE. I don't think so. No, this is a 6 percent increase over FY 2008—and, among the domestic agencies, as far as I know, this is one of the best increases.

CALIFORNIA FIELD OFFICE CLOSINGS

Ms. LEE. Okay. Then let me ask you about the administrative costs, though, as it relates to closing of offices and where we would identify that in the budget.

Mr. ASTRUE. Yes.

Ms. LEE. It is my understanding—and I know in California, and I would just like to ask you about the office closing there, that you do plan to close some offices. Secondly, I want to ask you about the use of technology and, of course, the Internet, which we all agree with in terms of upgrading and making sure that we are in the 21st century.

Mr. ASTRUE. Right.

Ms. LEE. But we do have a huge digital divide still in our country, especially with seniors and with the disabled community. So as you move toward closing offices, I know you are talking about relying more on technology, so how do you propose to make sure, first of all, that this works and that it makes sense.

Mr. ASTRUE. Sure.

Ms. LEE. And I know for a fact that now—I know in California and in my area, you know, seniors and the disabled have to travel 50 to 100 miles in many parts of the country also.

Mr. ASTRUE. Right.

Ms. LEE. So how does this make sense for the population of people that need offices close to where they are and need to be able to access staff to help them out?

Mr. ASTRUE. Multiple great questions there, and if I don't answer them all fully, come back to me. I am going to do my best.

There is some misinformation about the field office situation. The Agency, for 30 to 40 years, has had a very similar process for doing a limited number of consolidations and closings as leases come up. Generally, it is to get a small amount of efficiency because we don't have the budget to increase the number of field offices to try to move some resources into rapidly expanding parts of the country. The number of field offices in the last decade has stayed approximately the same; it has gone from about 1,287 to 1,261.

There is nothing dramatic happening in terms of the field. There has been a slight drift down. And we may have a few smaller; we may stay level.

That is not as much of an issue as the fact that it doesn't do any good to have a field office if the lights are on and there aren't any employees there. This is a problem that we have in a number of offices. The continuing resolution and the fact that we couldn't hire staff to put people in some of these offices was a factor in deciding to consolidate and close a few of them last year.

In general, we need to do much more in terms of technology in order to take some of the burden off of people in the field. No one wants to substitute for those important, complicated, intimate conversations that the staff has to have with the public, but right now they are doing a lot of routine work, and we are moving very fast to try to automate that as quickly as possible.

Right now, when attorneys file appeals, even though the system is substantially electronic, they send a piece of paper that goes into the field office, and the field office staff has to input it in order to get it into the system. And, if they are overloaded, that can add six weeks of delay for the claimant, which is bad, and it also distracts the field office staff from the things they ought to be doing.

We have got the system coming in place now so attorneys can file online, and at some point we may look at mandating it, because that is a huge deadweight burden on people.

Our online electronic forms are just not satisfactory; they were put up very quickly eight years ago and they are not sufficiently user-friendly. We had a peak of up to about 10 percent of the people using them and then we stopped. So we have got a whole overhaul going. It is going to happen in two parts. We will be about halfway there in September; the rest will come in—

On the technological divide, there are some urban legends out there that aren't true, even within our Agency. You have a terrific Regional Commissioner out in San Francisco, I believe in your district, who is experimenting with some things that are very important in that regard because there is a myth that, for instance, filing online can't benefit SSI applicants, and, in fact, we—

[CLERK'S NOTE.—Later corrected to "are working with the homeless through advocacy groups to begin their SSI application online."]

Since those social workers often find it difficult to actually get the applicants into the field office, it turns out to be not only an efficiency for us, but a blessing for the applicants because they are much more likely to get the benefits that they are qualified for promptly since the people who are trying to help them can file online.

CALIFORNIA FIELD OFFICE CLOSINGS CONTINUED

Ms. LEE. And do you plan to close more offices in California?

Mr. ASTRUE. I don't believe that we have very much. We have a small number of consolidations and closings at any point. I actually don't find out unless there is essentially community and political opposition. Actually, you find out before I do. My understanding is there are about six that are under review for some sort of consolidation or closing now, but we will submit for the record. [The information follows:]

CALIFORNIA FIELD OFFICE CLOSINGS

There is only one office currently under consideration for closing in California.

DISABILITY WATERFALL

Ms. LEE. Thank you very much, Mr. Chairman.

Mr. OBEY. Mr. Commissioner, let me ask you just four or five questions, and then we are going to have to move on to the next panel before we get devoured by roll calls on the House floor.

Mr. ASTRUE. Sure.

Mr. OBEY. My understanding is that, initially, 65 percent of applicants for disability are denied. Is that right?

Mr. ASTRUE. That is approximately right, yes.

Mr. OBEY. At the end of the process, what does that number turn into?

Mr. ASTRUE. That affects a little under a million people who get the benefits—

Mr. OBEY. I want to know what is the percentage in the end that are denied.

Mr. ASTRUE. About 85 percent of the decisions hold from the State level, so the overall percentage would be around 40 percent. We will provide you with a precise number for the record.

Mr. OBEY. Clarify that for me. So you are saying that initially 65 percent of people are denied.

Mr. ASTRUE. Right.

Mr. OBEY. And you are saying eventually that—

Mr. ASTRUE. Subtract about 5 percent. So if you are talking about denials—I like to think in terms of allowances rather than denials, but if you do it the other way around, I think it is about 60 percent. Yes, about 60 percent.

Mr. OBEY. So you are saying that only 5 percent of those cases see their outcomes change?

Mr. ASTRUE. One of the frustrations that we have with the system is there is a certain percentage of people that shouldn't be applying in the first place, and they are there either because private insurance companies or States require them to file with us—

Mr. OBEY. I understand, but I don't have time for elaboration.

Mr. ASTRUE. Sorry.

Mr. OBEY. I just want to know the bottom-line answer.

Mr. ASTRUE. I think that your bottom-line answer is approximately 60 percent.

HEARINGS PROCESSING TIME

Mr. OBEY. I understand that your request will result in processing time being cut by 29 days.

Mr. ASTRUE. That is a very rough number. We are actually ahead of schedule now.

Mr. OBEY. What do you consider to be an optimal processing time and when will you reach it?

Mr. ASTRUE. That is a very fine question. Right now, the Agency—and it is a rough number—assumes about 270 days. I think it is an open question whether we can do better than that, but we do need to be——

Mr. OBEY. Just give me a bottom-line response. What do you think the optimal response time would be?

Mr. ASTRUE. I think it is somewhere between 180 and 270.

Mr. OBEY. And when do you think we will get there?

Mr. ASTRUE. Using the 270, right now we are on track, assuming that we get the appropriations that we request through 2013.

COMMISSIONER'S BUDGET

Mr. OBEY. In the law, as you know, you are required to prepare an annual budget that is submitted to Congress without revision.

Mr. ASTRUE. Yes.

Mr. OBEY. And that budget proposed an additional \$100 million for administrative resources.

Mr. ASTRUE. Yes.

Mr. OBEY. That is \$100 million above the President or \$100 million above base?

Mr. ASTRUE. I think it was a little less than \$100 million. Seventy-six million, Mr. Chairman.

Mr. OBEY. Can you detail for us what you will do with those resources?

Mr. ASTRUE. With——

Mr. OBEY. If you had them.

Mr. ASTRUE. Well, the \$76 million included two differences. One is I erroneously assumed that we would be doing the same number of CDRs as in the past, and OMB was more flexible about that. We will give you detailed information about that. So the only real difference is about \$20 million in the technology budget.

Mr. OBEY. So you are saying that the only thing that would have happened if you had gotten the extra money that you requested initially would be on the technology front?

Mr. ASTRUE. There is a marginal difference on the technology side, yes.

Mr. OBEY. That is all?

Mr. ASTRUE. Yes, I think that is right.

HEARINGS AND APPEALS REGULATION CRITICISM

Mr. OBEY. We have already had some comments. Let me simply say that I think it is safe to say that not just members of this Sub-

committee, but a lot of the stakeholders in the Congress and out are concerned with your proposals for changing the process, and I wonder whether, given the criticism that you have heard from sources so far, you have changed in any way what your plans are likely to be.

Mr. ASTRUE. If I correctly understand what I think you are alluding to, we took some criticism about a couple—we have about a 100-item hearings and appeals regulation, where two or three of the items took substantial criticism. We have already indicated to the Congress that we are going to step back from those, and we have been working pretty collegially with the advocate community. I think that the vast majority of what we are going to do, pretty much everything we are intending to do, seems to be the consensus and non-controversial at this point.

Mr. OBEY. Let me interrupt my question because Mr. Rehberg is here.

Mr. REHBERG. [Remarks made off microphone.]

Mr. OBEY. Why did he do that? [Laughter.]

VOICE. I always do differently than he does.

Mr. REHBERG. So I will not re-plow the old field. Thank you.

Mr. OBEY. Well, that is the first time. [Laughter.]

We do get along on this Subcommittee once in a while, don't we?

I am anxious to get to the next panel. We are only going to have about 35 minutes, I think, before we have some roll calls.

Let me simply say you expressed concern about what the Congress had done as a result of what happened in the 1980s.

Mr. ASTRUE. Yes, I did.

INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES

Mr. OBEY. I was on this Subcommittee in the 1980s and I remember those days, and in those days there was a very distinct atmosphere which sent the message that there was great pressure being applied from the top to try to push people into denial of claims. And what it reminded me of was the old comment that Ray Bliss said many years ago.

Ray Bliss, many years ago, under the Eisenhower Administration, was the party chairman, and he said once, to a number of people in his party's caucus, he said, boys, you don't have to vote against that stuff, we can just administer it to death. And that is what was going on in the 1980s.

Mr. ASTRUE. Mr. Chairman—

Mr. OBEY. The Congress didn't legislate the kind of shrinkage of rights that wound up being provided—

Mr. ASTRUE. And, Mr. Chairman, I am not disagreeing with you on that, so let me clarify because I was also part of the cleanup in the late 1980s.

I agree that there should be substantial independence of ALJs, but in the Agency we have a number of policies that had the absolute best intentions when they went in and over time had unintended consequences. I do think that the statute, which makes it difficult to take prompt action, hinders us when basically an ALJ has stopped working, assaults a colleague, or assaults someone else. I just think that we need to go back and revisit the statute.

Mr. OBEY. I understand—

Mr. ASTRUE. I am not suggesting that we reopen that, Mr. Chairman. We are on the same wavelength on that.

Mr. OBEY. I understand. My point is simply that regardless of what happens, the pendulum swings from one direction to the other.

Mr. ASTRUE. Yes, that is right.

Mr. OBEY. You wind up, you hope you reach a happy medium, but you are often veering off in one direction or the other. I just wanted the record to be clear about what the problem was and why the actions were taken at that time.

Mr. ASTRUE. I think we are in agreement, Mr. Chairman. I am not arguing with what was done and why at the time. I supported those types of things at the time. All I am saying is I think it may be over-broad now and the edges of it ought to be revisited.

Mr. OBEY. Is there anything else you would like to say before we move on to the next panel?

Mr. ASTRUE. Mr. Chairman, I am listening to you and all the advocates about the frustration that they have about the process, and the only thing I want to say is I share that, too. I had been out of government a long time. I came back specifically to try to fix this, and it has been a difficult and frustrating year. I think every year is going to be difficult and frustrating, but I don't think that I have any more important use of my time than to try to make this situation better, which is what I am trying to do.

Mr. OBEY. Okay.

Any other member of the Committee have any questions?

Mr. OBEY. All right, Mr. Commissioner, thank you very much.

Mr. ASTRUE. Thank you.

INTRODUCTION OF WITNESSES

Mr. OBEY. We have asked that the Commissioner arrange for several Agency officials to remain available for questions, as we hear from the next panel.

The next panel—and I would ask them to come to the table at this time. First of all, Inspector General Patrick O'Carroll, has been serving in that capacity since November 2004, after having served in other positions in the SSA OIG organization, including Assistant IG for Investigations and Assistant IG for Internal Affairs.

Rick Warsinskey is Immediate Past President of the National Council of Social Security Management Associations. He has been District Manager of the Downtown Cleveland Social Security Field Office for nearly 13 years.

Marty Ford is Co-Chair of the Consortium for Citizens with Disabilities Social Security Task Force. She has over two decades of experience on Federal public policy issues affecting people with disabilities.

Ronald Bernoski, Administrative Law Judge who has been hearing Social Security disability cases in someplace called Milwaukee, Wisconsin for 25 years. Judge Bernoski serves as the President of the Association of Administrative Law Judges.

If you are ready, why don't we begin with Mr. O'Carroll? And let me simply ask you to summarize your statements. We will put your full statements in the record.

Mr. O'CARROLL. Good morning, Chairman Obey, Congressman Walsh, and members of the Subcommittee. I thank the Subcommittee for this invitation to testify today. Like the Subcommittee, my office is committed to doing all it can to confront the many challenges that SSA faces.

QUANTIFYING THE DISABILITY BACKLOG

Of all the challenges SSA faces in administering the world's largest social insurance program, none is greater than the backlog of disability claims. SSA's most recent data indicates that the current number of cases awaiting a hearing decision is over 750,000, leading to an average waiting time of 499 days. The waiting time for appeals is unacceptable.

BALANCING SERVICE AND STEWARDSHIP

From the time of the OIG's inception in 1995, we have sought to help SSA strike the balance between service and stewardship. Action must be taken to reduce and then eliminate the lengthy delays faced by disability applicants without compromising the integrity of the system.

AUDIT: INITIAL CLAIM PROCESSING

As we all know, providing additional funding and resources to SSA creates an obligation to use those funds wisely. In 2004, we conducted an audit entitled Disability Determination Services Claim Processing Performance. We discovered that poor performing offices experienced the most attrition, had the lowest examiner-to-staff ratio, and purchased the most consultative examinations.

AUDIT: HEARING OFFICE BEST PRACTICES

Of course, the disability backlog occurs primarily in the hearing and appeals phase, rather than the initial determination process. In 2004, we released another audit entitled Best Practices in the Highest Producing Hearing Offices. We found that SSA issued a list of 24 best practices to hearing offices in 1993, but then issued 191 best practices in 2002 and then, in 2003, they issued another list of 271 best practices. The sheer number made it difficult for hearing offices to determine which to implement, and some were even contradictory. We recommended that SSA revert to a shorter, clearer list of best practices.

AUDIT: HEARING OFFICE STAFFING

Next, in 2005, we issued an audit report entitled The Effects of Staffing on Hearing Office Performance. We found that during the five previous years the number of dispositions per ALJ had improved, from 2.03 to 2.4 cases. Yet, the timeliness had declined, from 316 days to 391 days. We also found that the national average staffing ratio was 4.7 staff per ALJ. However, office staffing ranged from a national low of 3 per ALJ to a high of 18.5 to an ALJ.

AUDIT: ADMINISTRATIVE LAW JUDGE CASELOAD PERFORMANCE

Sixty-three percent of the offices with a ratio below the national average had disposition rates below the average. Our most recent

review in this area examines ALJ caseload performance. We found wide variations in ALJ performance among hearing offices, ranging from 40 to 1,805 dispositions per year. We noted that if the performance of ALJs at the low end of the spectrum continues, it will have a negative effect on the disability backlog.

We further surmised that the lack of any formal performance accountability is a key reason for this inconsistency. So we recommended that SSA establish standards, examine offices where ALJs have high productivity, identify offices where ALJs have low productivity, issue best practices, and then take corrective actions.

AUDIT: JUDGE AND HEARING OFFICE PERFORMANCE

At the request of Chairman McNulty and Ranking Member Johnson from the SSA Subcommittee, we are conducting a review of Administrative Law Judge and hearing office performance. We are examining performance factors, ODAR management tools, and initiatives aimed at increasing ALJ productivity. We expect to complete this work in June.

AUDIT: HEARING OFFICE TECHNOLOGY

On another front, we looked at technical support for the hearing operation. In 2006, we examined the Case Processing Management System, or CPMS, to assess its ability to improve workload management at hearing offices. We found that ODAR management did not always use CPMS reports in their caseload management, particularly with respect to stagnant cases.

In 2007, we conducted an audit of management's use of workload status reports at hearing offices. We found that more than 50 percent of the cases were not being tracked at all, including hundreds of thousands of unworked cases. Most recently, we have initiated a review involving the timeliness of medical evidence submitted to the hearing offices.

CONTINUING DISABILITY REVIEWS

Finally, there is no more important aspect of stewardship than the continuing disability reviews, the process by which SSA learns that beneficiaries' disabling conditions may no longer preclude them from working. I applaud the Subcommittee's support of these reviews and encourage your continued support of stewardship.

Thank you. I will be happy to answer questions.

[The prepared statement and biography of Inspector General O'Carroll follow:]

U.S. House of Representatives

Committee on Appropriations

**Subcommittee on Labor, Health and Human
Services, Education, and Related Agencies**



Statement for the Record

**Reducing the Disability Backlog at the Social Security
Administration**

**The Honorable Patrick P. O'Carroll, Jr.
Inspector General
Social Security Administration**

February 28, 2008

Good morning, Chairman Obey, Congressman Walsh, and members of the Subcommittee. It's a pleasure to be here today, and I thank the Subcommittee for the invitation to testify, and for your commitment to the efficient and accurate operation of the Social Security Administration (SSA). Efficiency and accuracy in SSA's operation is of course more than an issue of preventing the waste of appropriated funds; it is a critical public issue affecting millions of Americans every day. Like this Subcommittee, and like SSA itself, my office is committed to doing all it can to confront the many challenges that SSA faces in bringing critical benefits to the people who rely on them for their well-being.

Of the challenges inherent in administering the world's largest social insurance program, SSA currently faces none greater than the backlog of disability claims. SSA's data as of the end of January 2008 indicate that the number of cases waiting for a hearing decision was 751,767, leading to average waiting times for FY 2008 of 499 days. This waiting time for appeals is unacceptable, and despite SSA's efforts over the past several years, the delays have actually increased, rather than decreased. Since taking office, Commissioner Astrue has renewed and reinvigorated SSA's efforts to reduce these backlogs. My office is working closely with him in this regard, and I am confident that through our efforts, and with Congress' assistance, we will be able to make significant headway.

I am particularly pleased that in attempting to reduce the backlog, Commissioner Astrue is cognizant of the need to maintain the integrity of the process. From the OIG's inception in 1995, we have sought to help SSA strike the balance between service and stewardship. Since that time, we have succeeded in helping SSA maintain its reputation for quality and responsive public service, while significantly improving the accuracy and integrity of SSA's programs. Unfortunately, the exception to SSA's service reputation is the disability backlog. Action can and must be taken to reduce, and then eliminate, the lengthy delays faced by disability applicants, without compromising the integrity of the program.

To address this challenge, SSA must address problematic issues in a number of areas:

First, the structure of the SSA components that oversee the disability process has already been studied, streamlined, and improved through a joint effort between SSA and the OIG, and I'll describe that effort in detail in a moment.

Second, issues of staffing, productivity, and the use of technology, particularly in SSA's 140 hearing offices must be addressed. Are the hearing offices adequately and appropriately staffed, with an efficient ratio of support personnel to judges, to ensure that they are performing at maximum efficiency? Are hearing offices, and Administrative Law Judges (ALJ) in particular, operating at acceptable and consistent levels of productivity? And is SSA making full use of available technology, from case management systems to electronic disability folders, to improve the disability process and hearing office performance? The OIG has completed audit work in these areas, and is both performing and planning additional work, and I will describe those efforts as well.

Third, SSA, with the help of the OIG and Congress, must continue to seek new and innovative ways to improve the disability process and reduce waiting times. Over the years, various plans have been introduced and piloted or implemented with varying degrees of success. Under a new Commissioner, new ideas must be brought forward to improve critical service delivery to disability applicants.

Finally, I spoke a moment ago of stewardship, and in this vein, any plan for improvement in the disability adjudication process must include mechanisms to ensure that the evidence being used to adjudicate claims is genuine and that claims are being adjudicated fairly, accurately, and consistently. Again, my office has performed work in this area that should assist the Commissioner in his plans to reduce the backlog, and more work is in process.

With all of these issues in mind, we are working closely with SSA on new and innovative approaches to old problems, and I applaud the Commissioner for his dedication and ingenuity. I'd like to address each of these issues to give the Subcommittee a comprehensive understanding of the OIG's work in these areas and our role in reducing the disability backlog.

Management Structure

As I mentioned earlier, one of Commissioner Astrue's first actions upon taking office was to examine the management structure of SSA.

Prior to Mr. Astrue's arrival at SSA, the Agency had for some years been planning and implementing its Disability Service Initiative (DSI), a comprehensive redesign of the disability determination process. The development of DSI had altered several aspects of the Agency's structure, particularly within the Office of Disability and Income Security Programs (ODISP). Since Commissioner Astrue would proceed with some, but not all, aspects of DSI, it was not clear that the current management structure remained appropriate to his plans.

To that end, he requested that the OIG conduct an evaluation of ODISP, the component responsible for directing and managing the planning, development, and issuance of operational regulations, standards and instructions for the OASDI and SSI programs. He requested that this review be conducted in a 6-week timeframe, that it be as comprehensive as possible, and that it include recommendations for any restructuring that the OIG thought would better enable SSA to confront the disability backlog.

That review determined that ODISP was not focused solely on planning and program policy issues, but was responsible for several operational functions that detracted from its primary policy function. In addition, we found communication lacking, both within ODISP and between ODISP and other SSA components. We also believed that some functions within ODISP might be better aligned to improve coordination and

productivity, and that some operational functions appeared to be inconsistent with ODISP's mission and might be better managed elsewhere in SSA.

In light of our findings, we provided the Commissioner with a detailed list of recommendations for the restructuring of ODISP, the redistribution of certain ODISP functions, and the centralization of SSA's policy function, which was in many ways shared between ODISP and SSA's Office of Policy, creating unnecessary redundancy and confusion.

SSA generally agreed with our recommendations and made sweeping changes to the management structure of ODISP in particular, and of other components. These changes have laid the framework for improvements to multiple SSA processes, including the disability adjudication process.

Staffing, Productivity, and Technology

Staffing levels, the productivity of staff, and efficient use of technology are key elements in improving the disability appeal process. If staffing is insufficient, and if productivity is substandard or inconsistent, timeliness and accuracy (service and stewardship) both suffer. Moreover, providing additional funding and resources to SSA creates an obligation to use that funding wisely. All staff should have access to appropriate technology to maximize performance and accuracy. With this in mind, the OIG has conducted several audits to assist SSA.

Total case processing time is not only a reflection of the efficiency of SSA's hearing offices, but of the time it takes for initial claim determinations to be made in the State Disability Determination Services (DDS) that make these initial decisions. In 2004, we conducted an audit entitled *Disability Determination Services' Claims Processing Performance*, intended to identify factors that may have resulted in differing levels of performance at selected DDSs.

We selected 10 DDSs according to a formula designed to provide a relevant sample that would include both high- and low-performing offices. In reviewing each of the 10, we discovered that poor-performing offices were consistently those that experienced the most attrition, the fewest disability examiners in relation to total staff, and those that purchased consultative examinations with the most frequency, rather than waiting for medical documentation from the treating physician that is often delayed.

We made several recommendations, including that SSA continue to work with the States to resolve these delaying factors, initiate a staff model mix with an optimal ratio of examiners to total staff, and initiate outreach efforts to speed the receipt of treating physician evidence.

Of course, the disability backlog lies primarily in the hearing and appeals process rather than in the initial determination process. Looking at those staffing and productivity issues we released another audit report in 2004 entitled *Best Practices in the Highest*

Producing Hearing Offices. We found that an earlier practice of soliciting and identifying best practices in hearing offices had resulted in 24 best practices that hearing offices had found helpful in improving performance. That practice, however, had been eliminated, and instead, in 2002 and 2003, the former Office of Hearing and Appeals (OHA) issued two “best practices” memoranda, the first listing 191 best practices, the second list 271. The sheer numbers of these best practices made it difficult for hearing offices to determine which to implement, and some of the best practices were contradictory.

We recommended that OHA (now the Office of Disability Adjudication and Review, or ODAR) return to its prior practice of soliciting and distributing a shorter, clear list of best practices. We also outlined in our own report the most commonly-used and apparently successful practices, and recommended that OHA share that information with its hearing offices. SSA agreed with our recommendations.

Turning from best practices to support staff issues, in 2005 we issued an audit report entitled *The Effects of Staffing on Hearing Office Performance*. In that audit, we found that during the 5 previous years, the number of dispositions per day per ALJ had improved (from 2.03 to 2.40 cases), yet timeliness had declined (from 316 to 391 days). While some factors contributing to this apparent contradiction were beyond SSA’s control (such as an ALJ hiring freeze and an increase in claims) the decline in timeliness could result to some extent from SSA’s allocation of staff. We found that while the national average staffing ratio was 4.7 support staff for each ALJ, offices ranged from a national low of 3 support staff per ALJ to a high of 18.5 support staff per ALJ. Of the 76 hearing offices with a ratio *below* the national average of 4.7 to 1, 63% had disposition rates below the national average.

This suggested that disposition rates and timeliness were related to staffing levels. While increasing staff in every hearing office was not an option, making sure that staffing levels were consistent surely was. We recommended that SSA establish and implement an ideal staffing level ratio for hearing offices nationwide, and provide contract-based file assembly assistance to those offices whose disposition rate remained below average even with appropriate staffing ratios. SSA agreed with our recommendations, and it is our hope that they will make these recommendations part of their initiative to hire new ALJs.

Our most recent review in this area examines ALJs’ caseload performance, an issue that goes hand-in-hand with the staffing of hearing offices and consistency among hearing offices. In this audit, we sought to evaluate the effect of varying ALJ caseload performance on the disability claim process and the backlog. We found wide variations in ALJ performance among hearing offices. In fact, during fiscal year 2006, ALJs processed cases ranging from a low of 40 per ALJ to a high of 1,805. Further, about 30 percent of ALJs processed fewer than 400 cases per year. This is a cause for concern, as the agency has indicated an expectation of at least 500 cases per year for each ALJ. We concluded that if the performance of ALJs at the low end of the spectrum is permitted to continue, this will continue to have a negative effect on the disability backlog.

We further surmised that the lack of any formal performance accountability process for ALJs is a key reason for this inconsistency in performance and in the resulting negative effect on the backlog. Conflicting opinions between the Agency and the union representing the ALJs as to the propriety of establishing ALJ performance standards has thus far frustrated attempts to impose such standards. We recommended that SSA establish standards, examine offices where ALJs have high productivity and issue best practices based on the operation of those offices, and identify offices where ALJs have low productivity to ascertain the causes and take corrective actions. SSA agreed with our recommendations.

We also have a related audit in progress, undertaken at the request of Congressmen Michael McNulty and Sam Johnson. We have begun a review entitled *Administrative Law Judge and Hearing Office Performance*. In that study, we are examining factors that affect ALJ and hearing office performance, ODAR management tools, and SSA initiatives aimed at increasing ALJ productivity. We believe that this audit may provide the Commissioner with important recommendations to improve hearing office performance and productivity, and will provide Congress with critical information with respect to funding and staffing levels.

To make the most of better distributed and more productive staff, it is critical that full advantage be taken of available technology. Case management software is critical to efficient operation, and the use of electronic folders can eliminate lengthy delays in adjudications caused by searching for and transporting millions of claims and hearing folders.

SSA's Electronic Disability, or e-Dib, initiative uses technology to improve performance in the disability programs. Specifically, the goals of eDib are to expand use of the Internet for completing disability-related forms, to automate the disability claims intake process, to provide electronic access to disability-related information and ultimately to produce a paperless disability process. Another important aspect of this process is the use of technology to track disability appeals and provide helpful and accurate management information. In a 2001 audit, we found that the Hearing Office Tracking System (HOTS), the predecessor to the current Case Processing Management System (CPMS), had inaccurate data and lacked consistent management controls over data inputs. CPMS was established, in part, to improve data reliability and management controls.

In 2006, our Office of Audit examined CPMS to assess its ability to improve workload management at hearing offices. We found that unlike HOTS, CPMS management reports were accurate, but also found that ODAR management did not always use CPMS reports in their caseload management, particularly with respect to stagnant cases, identified in CPMS' "No Status Change" indicator. We made recommendations to improve the use of CPMS as well as to more effectively use CPMS to identify potentially violent claimants, and SSA agreed with our recommendations.

A year later, we conducted an audit entitled *Management's Use of Workload Status Reports at Hearing Offices*, which was designed to assess the "No Status Change" indicator. That indicator can be attached to a case by CPMS at 12 different stages of case processing, from "Master Docket," where the case is first entered into CPMS, to "Mail," where the final decision is sent to the claimant. The number of days that must elapse before the "No Status Change" indicator is attached (and the case appears in the "No Status Change" management report), varies for each of the 12 stages.

We examined the workload status reports to determine where bottlenecks occurred that would significantly delay case adjudications and identified the three most significant obstacles to timeliness. We also found that more than 50% of cases were not being tracked at all, including hundreds of thousands of unworked cases. We made several recommendations to SSA to improve its processes to take full advantage of CPMS, and SSA agreed with our recommendations.

Most recently we have initiated a review entitled *Timeliness of Medical Evidence at Hearings Offices*. On October 29, 2007, SSA issued a notice of proposed rulemaking, which proposed revisions of policies and standards affecting the timeliness of medical evidence. This notice stated that untimely medical evidence causes ALJs to "...reschedule the hearing, which not only delays the decision on that case, but also delays the hearings of other individuals."

The Commissioner requested that the OIG determine what information is available to demonstrate that medical evidence at the hearing office level has been untimely. Our current evaluation is an expedited review of how untimely medical evidence can delay the hearings process, whether potential bottlenecks are being monitored by management, and the overall integrity of that management data.

Finally, I want to elaborate on my earlier reference to SSA's e-Dib initiative. Many aspects of e-Dib should have brought about significant improvements in the processing time of disability appeals. One such tool was the creation of electronic hearing folders that eliminates the often-lengthy delays incurred in locating and shipping folders around the country. Surprisingly, this and other e-Dib measures appear to have only marginally improved processing times or reduced the backlog. We are looking at ways to examine this phenomenon in order to supply SSA with recommendations on how e-Dib might be better used to improve performance.

New Approaches

Earlier, I mentioned DSI, the disability redesign plan created by the previous Commissioner of Social Security, which had just begun implementation when Commissioner Astrue took office. He took a hard look at DSI, and requested the OIG's input.

The OIG undertook the organizational review of ODISP that I described earlier, but we also conducted a review of one promising aspect of DSI, Quick Disability Determinations

(QDD), which was already operational in SSA's Region I and had shown some success. QDD claims are initial disability claims that are electronically identified by a predictive model as involving a high potential that the claimant is disabled, for which evidence can be easily and quickly obtained, and where the case can be processed within 20 calendar days of receipt. In our audit, we set out to determine whether cases selected for QDD were processed within the guidelines established by SSA, and to identify any possible improvements to the QDD process before it was expanded to SSA's other regions.

We found that QDD cases were generally processed within guidelines, but that SSA should consider improvements to the case selection process before expanding the program to other regions. Specifically, we found that while medical disability determinations were made quickly, non-medical case development was delaying payment to a significant degree. We also found that prioritization of QDD claims was problematic in that it did not take into account the 5-month waiting period for title II disability claims. Many such claimants were approved through QDD despite the fact that they would be unable to receive benefits for several months due to the waiting period. Meanwhile, title XVI claimants, who are eligible to be paid immediately, received no priority in the QDD queue, nor did title II beneficiaries nearing the end of their waiting period.

We recommended that SSA seek ways to accelerate the non-medical processing of claims to avoid reducing the benefit of the QDD process, and seek ways to prioritize QDD claims to avoid allowing claims that cannot yet be paid while delaying claims eligible for immediate payment.

We have a number of additional audits planned or in progress that we feel will assist SSA in reducing the disability backlog. These include studies of whether video hearings have had an impact on the backlog and how effectively hearing offices process cases remanded by the Courts. We will also continue our work on ALJ and hearing office performance and conduct an audit in which we study aged claims at the hearing level to identify actions SSA can take to reduce the backlog of these cases.

Accuracy and Integrity

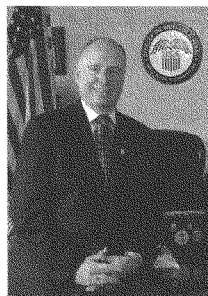
As I mentioned earlier, it is critical that in improving processing time and productivity, we not lose sight of accuracy and integrity. One stewardship initiative that has been a resounding success is the Cooperative Disability Investigative (CDI) program. Designed in the 1990s as a joint effort among the OIG, SSA, State DDSs, and local law enforcement agencies, the CDI program's mission is to detect fraud early in the disability adjudication process—at the time of initial application. Nineteen CDI units in 17 states receive fraud referrals from the State DDS. DDS staff, the experts in reviewing initial disability claims, are in the best position to identify possibly fraudulent benefit claims. They refer the case to the CDI unit, where it is further reviewed by a DDS examiner assigned to the unit. If it appears that fraud may have occurred, the examiner then hands the case off to the investigation team (an OIG Special Agent, who acts as team leader, and two State or local law enforcement officers).

The CDI program, in addition to preserving SSA funds by detecting fraud before benefits are ever paid, removes from the determination and appeal processes cases that will clearly never be allowed. In turn, this preserves resources in the DDS and in ODAR that can be used to adjudicate legitimate cases. During fiscal year 2008 to date, CDI has resulted in more than \$110 million in savings to SSA and other agencies. This successful program, which has grown from five to 19 units since its inception, is limited only by funding, and has been heralded as a success by GAO, which recommended placing CDI units in all 50 states.

Finally, there is no more important aspect to stewardship than Continuing Disability Reviews (CDR). The primary focus of today's hearing is the process by which disability claims are processed, adjudicated, and either allowed or denied. CDRs, however, are the only means (other than claimants who volunteer information that will stop their benefits) by which SSA learns that beneficiaries' disabling conditions may no longer preclude them from working. Ensuring that Social Security funds do not go to initial applicants who are not entitled is no more important than ensuring that beneficiaries already on the rolls remain entitled to benefits. I applaud the Subcommittee's support of CDRs and redeterminations and encourage your continued support in this area.

I have a very productive working relationship with Commissioner Astrue, and I know that SSA, like the OIG, is dedicated to improving service and reducing the disability backlog, ever mindful of the need to preserve stewardship and integrity in the process. I welcome the Subcommittee's interest, dedication, and support of our efforts, and look forward to continuing to work with you to deliver the right benefits to the right people with as little delay as possible. Thank you, and I'd be happy to answer any questions.

PATRICK P. O'CARROLL, JR.
Inspector General
Social Security Administration



Patrick P. O'Carroll, Jr. currently serves as the third Inspector General (IG) for the Social Security Administration (SSA), having been appointed to that position on November 24, 2004. Under his direction, the SSA Office of the Inspector General (OIG) inspires public confidence in the integrity and security of SSA's programs by conducting independent and objective audits, evaluations, and investigations. Since assuming the SSA OIG leadership, Mr. O'Carroll has intensified the OIG's efforts to identify and prevent fraud, waste, and abuse in SSA programs through the institution of innovative and collaborative approaches to the office's core functions and the management and development of human and technological resources.

The results of these efforts can be seen in the OIG's most recent achievements. In FY 2007, the OIG's investigators reported over \$380 million in investigative accomplishments through SSA recoveries, restitution, fines, settlements, judgments, and projected savings. OIG auditors issued 108 reports with recommendations identifying over \$3.1 billion in Federal funds that could be put to better use and \$1.2 billion in questioned costs. And OIG's attorneys reported over \$4.3 million in civil monetary penalties and assessments.

In addition to directing an OIG workforce of over 600 auditors, attorneys, investigators, and support personnel nationwide, Mr. O'Carroll also chairs the Investigations Committee of the President's Council on Integrity and Efficiency (PCIE)—an organization of Presidentially appointed Inspectors General who address issues that transcend individual Government agencies and increase the professionalism and effectiveness of IG personnel throughout the Federal Government. Under Mr. O'Carroll's leadership, the Committee seeks new ways to improve investigative functions, establish investigative guidelines, and promote best practices and training opportunities for thousands of agents in the Federal IG community.

Prior to his appointment as Inspector General, Mr. O'Carroll held a number of increasingly responsible positions in the SSA OIG organization, including Assistant Inspector General for Investigations and Assistant Inspector General for External Affairs. Mr. O'Carroll also brought to the OIG the benefits of his 26 years of experience with the United States Secret Service.

Mr. O'Carroll received a B.S. from Mount Saint Mary's College in Emmitsburg, Maryland, and a Master of Forensic Sciences from the George Washington University, Washington, D.C. He also attended the National Cryptologic School and the Kennedy School at Harvard University. Mr. O'Carroll is a member of the International Association of Chiefs of Police and the Association of Government Accountants.

Mr. OBEY. Thank you.

Mr. Warsinskey.

Mr. WARSINSKEY. Chairman Obey and members of the Subcommittee, my name is Richard Warsinskey, and I represent the National Council of Social Security Management Associations.

Chairman, let me say that many of the remarks you made at the very beginning I concur with. I think you were right on the mark.

I also coordinate the activities of the Social Security SSA Advocacy Group and I have been a manager of a Social Security office in Downtown Cleveland for 13 years.

I am pleased to have this opportunity to submit this testimony.

We are appreciative of the fact that Congress appropriated \$150,000,000 more for SSA in fiscal year 2008 than the President recommended. Even with this additional funding, we are very concerned about SSA's ability to provide a good level of service to the American public. Why?

First, the hearings backlog projection remains at 682,000 hearings in fiscal year 2009, well over the 312,000 hearings that were pending at the beginning of this decade. Over 400,000 of these hearings will eventually be approved. Hearings processing times are projected to be still in the 500 day range in fiscal year 2009, which continues to be an unconscionable amount of time to wait. The delays will continue to wreak havoc on the lives of thousands of individual Americans and their families. People will die waiting for an answer from Social Security.

Second, the Office of Disability Operations, which handles the back end of disability cases, has about 750,000 actions pending. The average amount of time it takes for a benefit authorizer to process a case they are assigned is 401 days. For a claims authorizer it is 484 days.

Third, the field office telephone service is deplorable. I repeat, deplorable. Over 50 percent of the 60 million-plus callers that try to contact Social Security offices receive a busy signal.

Fourth, visitors to field offices are at record levels and waiting times are climbing, while we are seeing increasing numbers of baby boomers filing for disability or retirement benefits and needing our assistance. The combined pressures of increasing numbers of visitors and telephone calls can be seen in a recent statement by a field office manager: We are juggling the impossible. The employers are dedicated and proud of their service to the public. The shortage of staff makes it harder to get done what needs to be done in an accurate and timely manner. We have all but given up on answering the phones because there is no one to do it.

Fifth, a significantly fewer number of medical continuing disability reviews and SSI re-determinations are being reviewed, costing taxpayers billions of dollars.

Sixth, staffing in SSA field offices, payment centers, and DDSs continues to drop. The agency staffing is at its lowest level since 1972, before we took responsibility for the SSI program. SSA staff retirements are accelerating due to a retirement wave within the agency itself. It takes a number of years for new staff members to be fully trained to handle the wide range of responsibilities.

A field office assistant manager recently described this challenge: We are trying to keep too many plates spinning with continual re-

ductions in staff due to retirement, promotions, and transfers. The best people, those with institutional knowledge, needed to keep this boat afloat, have been leaving and will continue to leave.

We certainly support at least the President's level of \$10,327,000,000 funding for SSA for fiscal year 2009. But to really address the challenges in SSA, we believe there needs to be a reserve fund of no less than \$240,000,000 established for program integrity workloads, plus an additional \$200,000,000 to \$250,000,000 in funding above the President's level. This increased level of funding would begin to immediately address the areas where SSA services need to be improved.

We realize that this is a significant increase in funding, but truly believe it is the level of funding necessary to begin to address the growing challenges facing SSA. We believe the American public demands and deserves to receive good and timely service for the tax dollars they have paid to receive Social Security.

Mr. Chairman, I thank you for this opportunity to appear before the Subcommittee.

[The information follows:]

**United States House of Representatives
Appropriations Committee
Subcommittee on Labor, Health and Human Services, and
Education, and Related Agencies
Written Testimony for the Record
of Richard E. Warsinskey, Past President
National Council of Social Security Management Associations Inc.
February 28, 2008**

Chairman Obey, Congressman Walsh and Members of the Subcommittee, my name is Richard Warsinskey and I represent the National Council of Social Security Management Associations (NCSSMA). I have been the manager of the Social Security office in Downtown Cleveland, Ohio for nearly thirteen years and have worked for the Social Security Administration for thirty-two years. I also help coordinate the activities of the SSA Advocacy Group. This group works to improve SSA's services at all levels. Members include many senior organizations, a number of disability support groups, SSA and Disability Determination Service associations, and Federal employee unions. On behalf of our membership and in support of our Advocacy Group, I am pleased to have the opportunity to submit this written testimony to the Subcommittee.

NCSSMA is a membership organization of nearly 3,500 Social Security Administration (SSA) managers and supervisors who provide leadership in over 1,300 Field Offices and Teleservice Centers throughout the country. We are the front-line service providers for SSA in communities all over the nation. We are also the federal employees with whom many of your staff members work to resolve problems and issues for your constituents who receive Social Security retirement benefits, survivors or disability benefits, or Supplemental Security Income. From the time our organization was founded over thirty-seven years ago, NCSSMA has been a strong advocate of efficient and prompt locally delivered services nationwide to meet the variety of needs of beneficiaries, claimants, and the general public. We consider our top priority to be a strong and stable Social Security Administration, one that delivers quality and prompt community based service to the people we serve, your constituents.

The Fiscal Year 2009 Budget and Past Budgets

The President has proposed a budget of \$10.327 billion for SSA's Limitation on Administrative Expenses (LAE) account for FY 2009. This is an increase of \$582 million over the FY 2008 funding level. It is also \$730 million more than what the President proposed for FY 2007. This significant increase in the President's recommended funding level for SSA is quite a departure from budget requests that have been proposed in recent years. In FY 2007, the President's proposed budget for SSA's administrative funding was only \$100 million over the proposed funding level for FY 2006.

We are supportive of this increased funding proposed by the President. We are also appreciative of the fact that Congress appropriated \$150 million more for SSA in FY 2008 than the President recommended. This reverses a five-year trend in which SSA has been appropriated on average about \$150 million less per year than the President's budget request. However, we believe that in order to meet all of SSA's service delivery responsibilities additional funding above the

President's budget is necessary. We believe an additional \$200-\$250 million above a potential reserve fund of no less than \$240 million for program integrity workloads would begin to address the areas where SSA's services must be improved and upgraded. **Thus we recommend total SSA FY 2009 administrative funding be no less than \$10.767-\$10.817 billion.** Our testimony below will detail the reasons why we believe additional resources are necessary.

How Reduced Investments Have Affected SSA Disability Services

The level of administrative funding that SSA has received in recent years has affected the agency's delivery of disability services in many ways. The following is a summary of a few key impacts:

- As of January 2008 about 751,000 cases, a near record high, were awaiting a hearing on an appealed claim, compared to only 312,000 cases at the beginning of FY 2000. Nearly 300,000 of these appeals are over 1 year old. Approximately 91,000 veterans have pending hearings. The average processing time for a hearing is currently over 500 days, up about 200 days from earlier this decade. These delays are in addition to the nearly nine months that precede most appeals for a hearing for the initial claim and reconsideration claim filing. In addition, if a hearing is denied claimants wait on average another 200 days for the decision from the Appeals Council.

The delays have wreaked havoc on the lives of thousands of individual Americans and their families. There have been many major media stories reported in the past year chronicling how disability applicants have lost their homes and families, and become more and more desperate as they wait for an answer from SSA. Many do not have health insurance, and without approval for Social Security and SSI, will not be able to get any insurance. Thus, their health continues to decline. Tragically, thousands of disability applicants have died while waiting for a hearing.

- The Disability Determination Services (DDSs) have lost over 1,100 positions since the beginning of FY 2006. As a result, their staffing levels are down nearly 8%. The attrition rate in recent years at the DDSs has averaged 12.7 % versus 6.8% for Federal government employees. (This is due primarily to the lower wage level of these jobs compared to other jobs within the area where these examiners work.) This has forced the DDSs to invest large sums of money in training new staff. This diverts precious dollars away from making quicker decisions.
- The Office of Disability Operations which handles the back end of disability cases currently has over 750,000 actions pending. This compares to 511,000 pending at the beginning of FY 2007. The average amount of time it takes for a Benefit Authorizer to process a case they are assigned as of the end of January 2008 is 401 days. For Claims Authorizers it is 484 days. This is a primary reason why Congressional offices receive so many requests for assistance regarding this part of the operation in SSA. This is occurring even though the Office of Disability Operations currently makes available 8 hours of overtime on Saturdays and 6 hours on Sunday. This Program Center has lost almost 600 positions since the beginning of FY 2005 and is losing a great deal of its institutional knowledge due to the retirement wave.

The seven Program Centers nationwide have lost nearly 1,400 positions since the beginning of FY 2005, and can only replace 1 for every 2 losses this year.

- In past years, funding shortages have forced SSA to cut back on program integrity activities, such as Continuing Disability Reviews (CDRs), which save \$10.30 in program costs for every \$1 spent in administrative dollars; and SSI eligibility redeterminations, which save \$7 for every \$1 spent in administration dollars. This year SSA plans to process only 235,000 CDRs. Due to reductions in processing CDRs in recent years, SSA is expected to have 1.225 million CDRs that should have been worked, but were instead deferred.

How Reduced Investments in SSA Field Offices Have Reduced Services

The level of administrative funding that SSA has received in recent years has affected the agency's Field Office services in many ways. The following is a summary of a few key impacts:

- 51% of callers who try to reach a Field Office receive a busy signal.
- Since the beginning of FY 2006, SSA's 1,267 Field Offices have lost over 1,700 Claims Representatives and over 520 Service Representatives.
- The combined impact of staffing reductions, the lack of funds for overtime to address ever-increasing workloads, and more visitors coming into Field Offices, has resulted in significant increases in waiting times in many offices for the public we serve. In many of SSA's larger urban offices, it is not uncommon for the public to wait in excess of two to four hours to be served by an SSA representative.
- This year SSA plans to process 1.2 million SSI redeterminations. This is 1 million fewer SSI redeterminations than were processed per year earlier this decade. These reductions are costing taxpayers a great deal of money: Billions of dollars. This is a key reason why the SSI benefit payment error rate has increased from 6.4% to 7.9% from FY 2005 to FY 2006.
- Since FY 2006, SSA has reduced the number of Field Offices by about 17 due to closing or merging of offices as the agency attempts to handle its increasing workloads with insufficient resources. SSA has also closed hundreds of contact stations in the past decade.

Impact of the FY 2008 Budget on SSA's Resources

SSA is planning to hire a net increase of at least 150 Administrative Law Judges this year with the increased funding for FY 2008. A judge clears an average of 500 hearings a year. This should begin to address the very large backlog of hearing claims.

SSA is planning on replacing these losses of positions during the actual period of this Fiscal Year:

- 7 of 10 losses in Field Offices
- 1.2 to 1 losses in Teleservice Centers
- 2 for 5 losses in Payment Centers
- 1 of 2 losses in the Disability Determinations Services (DDSs)

These replacements will not address the staffing losses that have occurred at the agency over the past several years and will only barely (except for the Teleservice Centers) address the losses this year. Thus, they will clearly not make these critical service components “whole.”

SSA's New Workload Challenges: The Baby Boomers

SSA will continue to face significant workload challenges in future years. Due in large part to the aging of the baby boomers, the number of workers receiving Social Security retirement benefits will increase by 13 million over the next 10 years. 78 million baby boomers will be eligible for benefits, or over 16,000 per working day. In a recent survey of NCSSMA members, one SSA Field Office supervisor made this fairly typical comment: *“We know that the baby boomers will be flooding SSA with applications. At the same time, SSA's baby boomer employees will be retiring too. We need to start hiring in the Field Offices so that the experienced employees can mentor/train the new employees to take over.”*

Those retiring have important decisions to make about collecting their Social Security. Many will receive over a quarter of a million dollars in benefits. In fact the maximum benefit at full retirement this year is over \$26,000 per year. There are many options to consider when filing for benefits. Should you take your benefit as early as 62 if you are retired? Should you wait until your full retirement age of 66? Or even delay drawing benefits until age 70 and receive an even larger amount? When should a spouse take benefits? When should a widow take benefits? How will working affect your benefits?

These are complicated decisions that will affect the retiree for the rest of their life, and SSA Field Offices have trained Claims Representatives that work with applicants to help them make these decisions. But in order to provide this very important service SSA needs to have a trained staff available.

On average, it takes 3 to 4 years for a Claims Representative to be fully trained. SSA makes a major investment in these positions. SSA is now facing a retirement wave of the employees brought on in the 1970s, resulting in a significant loss of the agency's institutional knowledge. It is imperative that SSA has an adequate number of Claims Representatives, an extremely important position in the agency. The challenge of the retirement wave is described in this statement by a Field Office Assistant Manager in our recent survey: *“We are trying to keep too many plates spinning with continual reductions in staff, due to retirement, promotions, and transfers. The best people; those with the institutional knowledge needed to keep this boat afloat, have been leaving, and will continue to leave. Quality of work has fallen by the wayside to ensure that percentages (goals) are met.”*

It is also important to note that the increased effort by SSA to offer an expanded number of internet applications does not significantly reduce the need for trained staff in the Field Offices. Claims filed over the internet need to be thoroughly reviewed by Claims Representatives. There also needs to be a thorough discussion with each applicant for benefits after they file to ensure they understand their options for receiving benefits. This challenge can be seen by a comment by a Field Office Manager from our recent survey: *“One would think that the internet availability and the TSCs are taking the majority of the workloads away from the Field Offices. But the reality is that the number of people visiting and calling the offices continues to increase. Having to take care of the public prevents us from processing pending workloads. Claims submitted in electronic format need Field Office intervention/review.”*

SSA Lifetime Warranty Service

SSA provides a lifetime of ‘warranty service’ to its beneficiaries. As the number of beneficiaries continues to increase SSA will need an adequate level of staff to provide the service they deserve and expect. The primary position that provides this assistance is the Service Representative position in the Field Offices and Teleservice Centers.

The agency is beginning to see the leading edge of the increasing demands of providing this ‘warranty service’ with the baby boomers now filing. Last year, an average of 870,000 people visited SSA Field Offices each week. Since June 2007, Field Offices have seen a significant increase in the number of visitors every week compared to the same time last year in all but a couple of weeks. Since the beginning of 2008, SSA Field Offices have been averaging about 950,000 visitors per week. In two separate weeks this Calendar Year, SSA Field Offices set all time record highs for recorded visitors. One Manager stated this in our recent survey: *The staff usually feels overburdened with the never-ending volume of interviews. They are usually one after the other daily with no ending. They are in need of time at their desks to process the numerous listings and actions that go with them.*

The above quote is a fairly typical description of life in SSA Field Offices. The staffs are running all day and have little time to train and complete thorough reviews of their cases. In October 2007, the AARP Bulletin published an article sent to approximately 30 million households entitled, *Social Security Meltdown: Will Anyone be Left to Help You?* The article provided a number of examples of how service has been degrading in Field Offices. The article concludes with this statement by a retiring employee: *I think what Social Security is looking at is the perfect storm.* (See: http://www.aarp.org/bulletin/socialsec/the_line_starts_here.html.)

It is important to note that SSA pays out about \$600 billion a year to all Social Security beneficiaries including \$100 billion to Social Security Disability beneficiaries. It also pays out about \$40 billion a year to SSI recipients. With these substantial amounts of funds being paid out it is imperative that the SSA staffs who administer these funds have the necessary training and time to accurately process cases. Otherwise it is pennywise and pound foolish.

SSA's Inadequate Field Office Telephone Service

SSA also handles an enormous volume of telephone calls to local Field Offices and Teleservice Centers. About 120 million calls are received by Field Offices and Teleservice Centers every year. The 800 Number had a busy rate of 7.5% in FY 2007 and handled about 59 million calls through agents and automation. At the same time over 60 million phone calls are directed to SSA Field Offices each year. In FY 2006, 51% of callers who tried to reach a local Field Office received a busy signal.

The combined pressures of the increasing numbers of visitors and telephone calls can be seen in this recent statement in our survey by a Field Office Manager: *"We are juggling the impossible. The employees are dedicated and proud of their service to the public. The shortage of staff makes it even harder to get done what needs to be done in an accurate and timely manner. We have all but given up on answering the phones because there is no one to do it!"*

For many years SSA has stated that it wants to improve the 800 Number services. The FY 2009 budget states that SSA plans to have a 10% busy rate for FY 2009 and an average of a 330-second answering time for a call. (This is unchanged from FY 2008.) However, few resources have gone into improving the Field Office telephone service. There is no mention of any additional staffing resources being allocated in the FY 2009 budget to improve the telephone service provided by SSA's Field Offices.

SSA Field Offices receive slightly more calls than the Teleservice Centers due in large part to language in the Omnibus Budget and Reconciliation Act of 1990. Two provisions in this act that apply are:

Social Security Notices-

Requires Social Security notices issued on or after July 1, 1991, to be written in clear and simple language and to contain the address and telephone number of the local office that serves the individual. If the notice is not produced in a local office, it must include the address of the local office servicing the individual and a telephone number through which that office can be reached.

Telephone Access-

Requires SSA to restore telephone access to local Social Security offices to the level generally available as of September 30, 1989, and to request the publication, in telephone directories, of telephone numbers and addresses of local offices that provide direct telephone access by May 4, 1991

As a result of the provisions above, all SSA notices must include the local telephone number. This means the public has the telephone number of the local Field Office to call in addition to the 800 Number. SSA must also publish the Field Office phone number in the local phone directories and online for those offices that published their phone number as of September 30, 1989.

Consequently, SSA Field Offices are being overwhelmed with phone calls. This has created two classes of phone service: The 800 Number which provides a barely adequate level of service and the Field Office telephone service, which NCSSMA must describe as deplorable.

Program Integrity Workloads

Earlier this decade, SSA Field Offices were processing 2 million SSI redeterminations and 800,000 medical Continuing Disability Reviews (CDRs) per year. The FY 2009 budget calls for 1,486,000 SSI redeterminations and 329,000 medical CDRs. This is over 700,000 fewer redeterminations and over 450,000 fewer CDRs per year than earlier this decade.

In FY 2006, the agency's SSI accuracy rate with respect to overpayments was 92.1 percent with an error rate of 7.9 percent, which represented improper payments of \$3.2 billion. This is a statistically significant difference from the FY 2005 error rate with respect to overpayments of 6.4%, which represented \$2.5 billion in improper payments. SSA directly attributes this increase in the error rate to the *reduction* in the number of redeterminations conducted in FY 2006.

In the *Appendix* (<http://www.whitehouse.gov/omb/budget/fy2009/pdf/appendix/ssa.pdf>) to the President's FY 2009 budget, it states that \$240 million should be used to perform additional CDRs and SSI redeterminations. The language indicates that of this \$240 million, \$40 million may be used to improve the disability claims process and \$34 million may be directed to SSI asset verification. Page 1126 of the *Appendix* provides a cross reference to the Budget Reform Proposals chapter in the *Analytical Perspectives* volume. (See: <http://www.whitehouse.gov/omb/budget/fy2009/pdf/spec.pdf>).

Pages 216-219 of the *Analytical Perspectives* volume cover program cap adjustments and a possible reserve fund for SSA. These pages also mention the possibility of creating a scoring rule in the Budget Resolution for specific program integrity activities. The *Analytical Perspectives* state that a cap adjustment of \$240 million would allow SSA to conduct an additional 140,000 CDRs and 635,000 SSI redeterminations in FY 2009. The *Analytical Perspectives* also mention that \$74 million can be used to improve the disability process and SSI asset verification. This section also states that with **\$240 million of expenses there would be \$2.6 billion in savings**. (The *Analytical Perspectives* also propose a cap adjustment of \$485 million in FY 2010 and \$518 million in FY 2011.)

On pages 22 and 23 of the *Executive Summary: Annual Performance Plan for FY 2009 and Revised Final Performance Plan for FY 2008* (<http://www.ssa.gov/budget/2009cjapp.pdf>) which are included in the *SSA Justification of Estimates for Appropriations Committees (FY 2009)*, it states that SSA plans to increase the number of SSI redeterminations from 1,200,000 in FY 2008 to 1,486,000 in FY 2009. This is an increase of only 286,000 instead of the 635,000 if a reserve fund were to be set up. Pages 22 and 23 also mention that the number of medical CDRs will increase from 235,000 in FY 2008 to 329,000 in FY 2009. This is an increase of 94,000 instead of the 140,000 if a reserve fund were established.

The *Analytical Perspectives* pages indicate that by setting up a **cap adjustment** or adding a **reserve fund of \$240 million for FY 2009** it would allow the agency to **process 349,000 more SSI redeterminations** (635,000-286,000) and **46,000 more medical CDRs** (140,000-94,000). In order to do this there would need to be a *\$240 million cap adjustment or the creation of a reserve fund* above the President's proposed funding level of \$10.327 billion. Again this would create a **savings of \$2.6 billion**.

Thus, if increased dollars could be set aside for SSA, the number of SSI redeterminations and medical CDRs that SSA performs could be increased substantially. This would result in a significant savings of funds for taxpayers.

The Case for Increased Investment in SSA

As mentioned earlier in this statement, the President's proposed FY 2009 funding level for SSA's administrative resources is \$582 million above the FY 2008 level. Unfortunately, these additional funds would not provide sufficient funds to cover many very crucial funding needs for SSA. Examples of just a few of the areas that need to be addressed at the agency:

- Nearly \$400 million of the \$582 million would be expended just to address mandatory cost increases such as rent, guards, postage, pay raises, and employee benefits.
- The hearings backlog is projected to remain at 682,000 hearings in FY 2009, well over the 312,000 hearings pending at the beginning of this decade. Hearing processing times are projected to still be in the 500-day range in FY 2009. The Appeals Council is not projected to have any improvement in their processing times with the target time staying at 240 days. This is true even with the additional hiring of Administrative Law Judges and many initiatives undertaken by SSA to streamline the hearings process. Most of this is due to the increased number of hearings that are expected to be filed. As a result, more resources will need to be invested in reducing the hearings backlog to a much more acceptable level, thus lessening the severe financial, physical and emotional impact of the protracted wait times.
- According to *SSA's Budget Appendix for FY 2009*, SSA's civilian full-time staff employment for Fiscal Year 2009 is expected to drop by about 864 employees. (See line 1001 on page 1126.) This, after already losing thousands of Claims Representatives, Service Representatives, DDS employees and employees in the Payment Centers in the last few years. Based on this level of staffing it is clear there will be little or no resources available to address the very deficient Field Office telephone service. NCSSMA has never seen SSA cost out what level of resources it would take to bring the Field Office telephone service up to the level provided by the 800 Number. We estimate that it would require many thousands more employees in local Field Offices to raise the level of service in these offices to an acceptable level. This single area of concern would justify a substantial increase in appropriated funding for SSA.

At a minimum, we believe SSA Field Offices need to add, on average, at least **four** members to the staff of an average size office of around 21 employees to address the phone traffic, deal with the increasing number of visitors, especially with the baby boomers filing, and process more SSI redeterminations and CDRs. This investment would certainly have a tangible long-term positive impact on providing improved services at SSA.

SSA Field Offices focus on hiring staff for a career. The base positions in Field Offices are the Claims Representative and Service Representative positions. It is widely acknowledged that the Field Office structure also serves as the future "farm club" for the rest of SSA, as these positions provide the in-depth understanding of the Social Security program necessary to work in management and other staff positions in SSA. An investment in additional Field Office staff would have many years of long-term return for SSA as a whole.

We also believe that a major infusion of resources is needed in the Office of Disability Operations which has over 750,000 actions pending. As mentioned above, the average length of time it takes for a Benefit Authorizer to process a case they are assigned as of the end of January 2008 is 401 days. For Claims Authorizers it is 484 days.

The DDSs have also suffered significant staffing losses. They will need more staff to process additional CDRs. In addition, with increased staffing levels they could review certain hearing cases to see if they can be approved. Since the DDS started looking at some of the hearings last year, they have approved nearly 13,000 cases.

One area where we believe that an increased investment in the disability area would reduce the backlogs and improve the fairness of the program is a truly random review of all initial and reconsideration disability cases. The review would be equally split between approvals and denials. Currently the law requires that 50% of all approved initial and reconsideration Title II disability cases and Title XVI adult disability and blindness cases be reviewed before a final approval is made. The intent of this was to lead to more consistency in approvals in all states as this review is done by SSA (a Federal Review) not the by DDSs.

However no more than 5% of the disapproved cases are reviewed. Thus, at least 95% of the denied cases are not reviewed. As a result, there is no early opportunity to prevent some cases from heading to the Hearings Office. This revised review method might actually be less expensive in the long run as it could reduce the very high cost resulting from a hearing on a case.

The Teleservice Centers need more staff to support the internet workload. The public needs to have online and phone support to contact when they have questions as they are filling out an internet transaction.

What will the cost be to provide these services? If a budget mechanism could be implemented to establish a reserve fund or cap adjustment for SSA this would certainly help pay for additional CDRs and SSI redeterminations to be processed. The President's budget suggests this amount should be \$240 million in FY 2009, \$485 million in FY 2010 and \$518 million in FY 2011. NCSSMA supports placing at least \$240 million into this fund. This is a very wise investment as \$240 million would save taxpayers \$2.6 billion in savings over a ten-year period.

In addition we support increased funding to begin to bring the Field Office telephone service up to the level of service provided by the Teleservice Centers and to provide the necessary staff to support the increasing number of visitors who need to be provided with a high level of quality advice. The Office of Disability Operations desperately needs more staff. This component receives a very high number of Congressional inquiries. The DDSs also need additional funding to improve their processing of disability cases and to assist the Hearings Offices.

And finally, more resources directed to the Hearings Offices and Appeals Council would lower the backlog.

The AARP Bulletin ran a second article in November 2007 entitled, "*They Died Waiting Lost in Social Security Hell.*" (See: http://www.aarp.org/bulletin/socialsec/sick_of_waiting.html). This article along with well over 100 other articles and news reports from all over the country published in the last year describe in vivid detail the damage that the growing backlogs have caused to so many Americans in recent years. We believe we must find a solution to this situation, and soon.

We recognize that Congress will not be able to fund all of these resource needs in FY 2009. The SSA Advocacy Group sent a letter signed by 44 group members to the Office of Management and Budget in November suggesting that SSA's funding for FY 2009 should be \$11.0 billion. We certainly recognize this would represent a considerable increase in SSA's budget. This is the amount that we believe is necessary to address the many challenges we have cited above. But, at the same time, **we believe an additional \$200-\$250 million above a potential reserve fund of no less than \$240 million would begin to immediately address the areas where SSA's services need to be improved and upgraded.** (The reserve fund could be higher to increase savings.) Therefore, **the total SSA FY 2009 administrative funding we recommend for FY 2009 is no less than \$10.767-\$10.817 billion** (\$10.527-\$10.577 billion plus a reserve fund of no less than \$240 million). We realize that this is a significant increase in funding, but truly believe it is the level of funding necessary to begin to address the growing challenges faced by the agency. If we do not address these challenges now, there will be a very real and negative impact on the citizens that we are obligated to serve every day.

It is very important to note that SSA's staff is at its lowest level since 1972, prior to SSA's assumption of the Supplemental Security Income program, while SSA's workloads are growing and will continue to grow at a very fast pace. In addition to the increased responsibilities mentioned above, SSA has also assumed responsibility for processing applications for the Low Income Subsidy and Income Related Medicare Adjustment provisions of the Medicare Modernization Act. With staff adjustments made only in 2005, and staffing gains due to MMA long since been lost to attrition.

SSA has a trust fund of about \$2.2 trillion dollars. The Social Security Trust Fund is intended to pay benefits to future beneficiaries and finance the operations of the Social Security Administration. The additional funding and investment we are proposing for SSA represent only a very small fraction of \$2.2 trillion. Certainly the workers of America deserve to have their taxes utilized to provide a fair and adequate level of service for the very benefits they worked so hard to receive.

Conclusion

We believe that the American public demands and deserves to receive good and timely service for the tax dollars they have paid to receive Social Security. **We urge that SSA be given increased funding above the President's FY 2009 budget request. This additional investment in SSA would certainly begin the necessary process to restore the levels of service that the public deserves from SSA.**

On behalf of the members of the NCSSMA and in support of the SSA Advocacy Group, I thank you again for the opportunity to submit this written testimony to the Subcommittee. NCSSMA members are not only dedicated SSA employees, but they are also personally committed to the mission of the agency and to providing the best service possible to the American public. We respectfully ask that you consider our comments and would appreciate any assistance you can provide in ensuring that the American public receives the necessary service that they deserve from the Social Security Administration.

Richard E. Warsinskey
Immediate Past President
National Council of Social Security Management Associations Inc. (NCSSMA)

Richard Warsinskey is the Immediate Past President of the National Council of Social Security Management Associations Inc. (NCSSMA). Prior to that he served as Vice President of NCSSMA and as an officer in the Chicago Regional Social Security Management Association, including serving as President. He helped develop and oversaw six national surveys of the Association membership this decade which can be found at www.ncssma.org.

Mr. Warsinskey also helps coordinates the activities of the SSA Advocacy Group. This group works to improve SSA's services to the American public at all levels. Members include many senior organizations, a number of disability support groups, Social Security Administration and Disability Determination Service associations, and Federal employee unions.

Mr. Warsinskey has been the District Manager of the Downtown Cleveland Social Security Field Office for nearly thirteen years. In addition to working in Ohio, he has also held management positions in Milwaukee, Chicago, Baltimore and Detroit. He has been very active at the Social Security Administration for a number of years in developing methods to share innovative best practices to improve the agency's productivity and quality.

Mr. Warsinskey has an MA in Political Science from the University of Wisconsin-Madison and a BA in Political Science from the University of Akron. His wife Barbara is a special education teacher. He has two children, Laura and David.

Mr. OBEY. Thank you.

Ms. Ford.

Ms. FORD. Thank you, Chairman Obey, Ranking Member Walsh and members of the Subcommittee. Thank you for this opportunity to testify.

Social Security and SSI benefits as well as Medicare and Medicaid coverage are the means of survival for millions of people with severe disabilities. They rely on SSA to promptly and fairly adjudicate their claims for disability benefits.

However, as you are aware from your own constituent services staff, delays and backlogs have reached intolerable levels. When a decision is appealed, individuals and their families can wait years for a hearing, wait again for a decision and then wait again for actual payment of benefits.

In the meantime, their lives are unraveling. Families are torn apart. Homes are lost. Medical conditions deteriorate. Financial security crumbles, and many individuals die before a decision is made. The media has reported on this extensively.

Other key services, such as action on a lost check or having earnings promptly recorded, have also diminished. Some local field offices have been threatened with closure and, despite dramatically increased workloads, staffing levels throughout the Agency are at their lowest since SSI payments began.

The primary reason for the increasing disability backlogs is that SSA has not received adequate funding for many years. The Agency does not have the resources to address its current workload or to face the retirement and disability applications from baby boomers along with the retirement of its own baby boomer workforce. While the system is clearly in crisis, without adequate appropriation, service will deteriorate even more.

The President's request for fiscal year 2009 is encouraging but does not go far enough for SSA to provide its mandated services at a level expected by the American public.

To meet its responsibilities, we believe that SSA needs at least \$11,000,000,000 for the fiscal year 2009 administrative budget. This should allow the Agency to significantly reduce the backlog as well as keep local offices open, provide telephone service to the public and maintain the integrity of the programs by performing more continuing disability reviews and SSI redeterminations.

We also recommend that SSA's administrative budget be removed from discretionary spending limits. The cost of running SSA is driven by its ever increasing workload. Most of the administrative costs are borne by the trust fund. Other important programs in the Labor HHS Appropriations Bill should not be impacted by the ever growing cost of administering Social Security.

Management issues will not be resolved solely with additional funding. SSA must continue to streamline and operate more efficiently. The Agency has already begun technological and other improvements in its business processes in numerous areas. We expect that these initiatives will assist in restoring the Agency's abilities to meet the needs of applicants and beneficiaries.

My written testimony includes recommendations for additional improvement. This includes improved development of evidence earlier in the process by doing a number of things including providing

more assistance to the claimant at the application stage, having the State DDS obtain necessary and relevant evidence, improving reimbursement rates to providers, giving better explanations to physicians and other sources about what evidence is needed, giving more guidance and training to adjudicators, improving the use of the current ways to expedite cases and improving the overall quality of consultative examiners or examinations.

While there may be additional ways to improve decisionmaking from the adjudicators' perspective, such initiatives must be tempered by how the process would affect the claimants and beneficiaries for whom the system exists, those who need the program and meet the criteria.

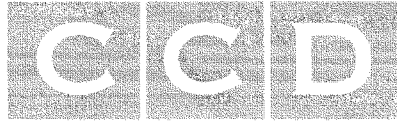
People who find they cannot work at a sustained and substantial level due to disability are faced with a host of personal, family and financial circumstances that will impact how effectively they can maneuver the very complex disability determination system. Many will not be able to address the requirements for proving eligibility without substantial assistance.

SSA must continue and improve its well-established role in ensuring that an individual's claim is fully developed before a decision is made and must ensure that its rules reflect this administrative responsibility.

We urge Congress to provide SSA with the resources necessary to carry out its mandated responsibilities and to substantially improve its service to the public.

Thank you for this opportunity.

[The information follows:]



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

Hearing on

**Reducing the Disability Backlog at the Social Security Administration/
FY 2009 Budget Overview**

**Subcommittee on Labor, HHS, Education and Related Agencies
House Committee on Appropriations**

February 28, 2008

**Testimony of Marty Ford
Co-Chair, Social Security Task Force
Consortium for Citizens with Disabilities**

On Behalf of:

**American Council of the Blind
American Network of Community Options and Resources
Association of University Centers on Disabilities
Council of State Administrators of Vocational Rehabilitation
Easter Seals, Inc.
Epilepsy Foundation
Goodwill Industries International
National Alliance on Mental Illness
National Association of Disability Representatives
National Disability Rights Network
National Industries for the Blind
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
Research Institute for Independent Living
The Arc of the United States
Title II Community AIDS National Network
United Cerebral Palsy
United Spinal Association**

Chairman Obey, Ranking Member Walsh, and Members of the House Appropriations Subcommittee on Labor, HHS, Education and Related Agencies, thank you for inviting me to testify at today's hearing on Reducing the Disability Backlog at the Social Security Administration/FY 2009 Budget Overview.

I am a member of the public policy team for The Arc and UCP Disability Policy Collaboration, which is a joint effort of The Arc of the United States and United Cerebral Palsy. I serve as the current Chair of the Consortium for Citizens with Disabilities (CCD), and also serve as a Co-Chair of the CCD Social Security Task Force. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

The focus of this hearing is extremely important to people with disabilities. Title II and SSI cash benefits, along with the related Medicaid and Medicare benefits, are the means of survival for millions of individuals with severe disabilities. They rely on the Social Security Administration (SSA) to promptly and fairly adjudicate their applications for disability benefits. They also rely on the agency to handle many other actions critical to their well-being including: timely payment of their monthly Title II and SSI benefits to which they are entitled; accurate withholding of Medicare Parts B and D premiums; and timely determinations on post-entitlement issues that may arise (e.g., overpayments, income issues, prompt recording of earnings).

We appreciate SSA's attention to improving services for people with disabilities within its limited resources and the agency's efforts to improve its technological capacity in ways that will help to accomplish its work. However, under the current budget situation, people with severe disabilities have experienced increasingly long delays and decreased service in accessing these critical benefits. Processing times have grown, especially at the hearing level where delays have reached intolerable levels. In some hearing offices, claimant representatives report that claimants wait more than two years to receive a hearing and decision. There are thousands of cases that have been pending 900 days or longer.

We believe that the main reason for the increase in the disability claims backlogs is that SSA has not received adequate funds to provide its mandated services. Commissioner Astrue has made reduction – and elimination – of the disability claims backlog one of his top priorities. While the current situation is dire, without adequate appropriations to fund SSA, the situation will deteriorate even more.

We are encouraged by recent Congressional efforts to provide SSA with adequate funding for its administrative budget. The Fiscal Year 2008 appropriation for SSA's Limitation on Administrative Expenses (LAE) was \$9,746,953,000. This amount was \$148 million above the President's request and was the first time in years that the agency has received at least the President's request.

While the FY 2008 appropriation will allow the agency to hire some new staff and to reduce processing times, it will not be adequate to fully restore the agency's ability to carry out its

mandated services. Between FY 2000 and 2007, Congress appropriated less than both the Commissioner of Social Security and the President requested, resulting in a total administrative budget shortfall of more than \$4 billion. The dramatic increase in the disability claims backlog coincides with this period of under-funding the agency, leaving people with severe disabilities to wait years to receive the benefits to which they are entitled.

People with severe disabilities have been bearing the brunt of the backlog crisis. Behind the numbers are individuals with disabilities whose lives have unraveled while waiting for decisions – families are torn apart; homes are lost; medical conditions deteriorate; once stable financial security crumbles; and many individuals die. Numerous recent media reports across the country have documented the suffering experienced by these individuals. Access to other key services, such as reporting that a check has not been received or promptly recording earnings, also has been diminished. Local SSA field offices have been threatened with closing or having their hours open to the public reduced. Despite dramatically increased workloads, staffing levels throughout the agency are at the lowest level since 1974 when SSI payments began.

The President's request for the SSA FY 2009 LAE is encouraging, but does not go far enough to put the agency on a clear path to provide its mandated services at a level expected by the American public. In order for SSA to meet its responsibilities, we estimate that the agency needs a minimum of \$11.0 billion for its FY 2009 administrative budget. This amount will allow the agency to not only significantly reduce the backlog, but also keep local offices open, provide adequate telephone services to the public, and maintain the integrity of its programs by performing more continuing disability reviews and SSI redeterminations. We also recommend that SSA's LAE budget authority be removed from the Section 302(a) and (b) allocations for discretionary spending.

In my testimony today, I will discuss (1) the impact on people with disabilities of insufficient funding for SSA's administrative budget and (2) ways that SSA can reduce the backlog of disability claims and improve the disability claims process.

I. The Impact on People with Disabilities of Insufficient Funding for SSA's Administrative Budget

Other witnesses today will address the current state of SSA's inadequate level of resources. However, we must recognize the real-life impact of the backlog and the ensuing delays for individuals with disabilities who must file claims for disability benefits and wait for a decision. Over the past year, there have been numerous media stories both national and local in newspapers, on the radio, and on television, which have documented the suffering experienced by these individuals. For example, a December 2007 New York Times front-page article¹ told several compelling stories:

¹ "Disability Cases Last Longer as Backlog Rises," by Erik Eckholm, *New York Times*, Dec. 10, 2007.

- A North Carolina woman had a hearing three years after her initial application was denied. She used an oxygen tank 24 hours a day because of emphysema and sleep apnea. She had lost her apartment and slept on her daughter's sofa or at a friend's house.
- A North Carolina man's application was denied in 2003 despite severe diabetes and numerous hospital records and doctors' opinions. His parents went into debt because of his medical bills and nearly lost their home. They obtained a lawyer to represent their son who still had to wait two years for a hearing. The parents were notified that their son, fearing another rejection, committed suicide, just two hours after his attorney called to say that the administrative law judge had approved the claim without the need for a hearing.

There are many other similar stories across the country. Testimony presented in Congress last year by a CCD-member organization² described circumstances facing a sampling of claimants and demonstrates in human terms the terrible impact of the delays and the crises facing claimants every day:

- An Alabama man, a former welder, had a stroke when he was only 48 years old. While waiting 18 months for his hearing, he cashed in all of his savings bonds and his health deteriorated. He had to move in with his elderly mother who had lung cancer. He had no means of support after she died and his brother lost his job after he had to move to Alabama to help out.
- An Arizona father of six, a former construction worker, watched his wife develop a substance abuse problem because of their financial problems. This family had a history with delays – the claimant's father died after suffering a heart attack caused in part by delays in processing his own disability claim.
- A former cook and professional musician in Idaho with cancer pawned his belongings to survive while waiting for his hearing. Without health insurance, he was not able to receive consistent medical care for his cancer.
- To survive while waiting for a hearing decision, an Iowa woman cashed out her work pension plan, paying early withdrawal penalties. She borrowed money and took out a lien on her car. She received inadequate medical care because she had no medical insurance.
- A veteran in Kansas has been unable to pay the rent for his VA transitional program and became homeless.
- In Kentucky, a single father of five (his wife committed suicide) with heart problems and other conditions had to give up a promising heart treatment when he lost his medical insurance while waiting for a hearing.
- A Maine father became homeless with his wife and two children while waiting for a hearing. After eviction, the family could not stay in a shelter because of the children and they lived in his car.
- A Massachusetts mother of two young daughters lived in a shelter after leaving an abusive domestic situation. Her hearing request, filed in January 2006, was lost and logged in 15 months later in April 2007 when she obtained an attorney.

² Testimony of Nancy G. Shor, Executive Director, National Organization of Social Security Claimants' Representatives (NOSSCR), before the House Ways and Means Social Security Subcommittee, "Hearing on the Social Security Administration Disability Claims Backlogs," February 14, 2007, and before the Senate Finance Committee, "Hearing on Funding Social Security's Administrative Costs: Will the Budget Meet the Mission?," May 23, 2007. NOSSCR is a member of the CCD Social Security Task Force.

- A woman in Montana lived in an 8 foot by 20 foot building, with no plumbing. She previously lived in a mold-infested trailer without running water, a bathroom, or cooking facilities. She had no insurance and was unable to pay her doctor for four years.
- A New Mexico father of four with leukemia, who is a former pipeline inspector, filed for bankruptcy because his wife's income could not support the family.
- A New York mother, a former State employee, was evicted and lost custody of her children when she could not provide a home for them. She lived in a homeless shelter for four months. Her depression, which worsened due to stress, resulted in a hospitalization.
- A former tugboat captain in North Carolina had no insurance and could not obtain surgery for his back. A request to expedite his hearing to avoid foreclosure was denied. He lost his home, forcing him to move in with his elderly and ailing mother.
- Even though a man in North Dakota had a rare form of a brain tumor and failing kidneys, his claim was denied and he filed an appeal. He and his wife had financial problems paying for his medications and medical bills and they applied for heating assistance.
- An Ohio man with diabetes requires multiple surgeries because of an open stomach wound. He lost his apartment and moved in with a friend, which was detrimental to his wound because he required a very clean environment.
- An Oregon man died in June 2005 at age 41 because of heart disease. He was homeless and moved frequently. His hearing, requested in 2004, was held in 2007, long after his death.
- A Pennsylvania woman spent all of her savings and had to apply for welfare. Her house went to foreclosure but was saved by her fiancé. He had cancer and a poor prognosis and she worried that without him, she would lose her house and become homeless.
- The file of a Rhode Island resident sat in the SSA district office for more than two years after a hearing was requested in 2004. The hearing office returned the request to the SSA district office because it did not have a claims folder attached. The hearing request and folder were finally sent to the hearing office in January 2007, after an attorney became involved.
- A Texas woman, a former broker who has a Master's Degree, lost her income and health insurance after filing for benefits. She also lost her home and has exhausted her savings to pay for medical care. After living with friends, she went to live with her elderly parents.
- While his hearing was pending, a Washington veteran became homeless and lived at a local mission. Before becoming disabled, he successfully sold cars. Upon leaving his hearing, his attorney drove him to the mission to pick up a paper bag with all of his possessions and then drove him to the local VA hospital for in-patient medical treatment.
- A long-time municipal government employee in West Virginia was having serious financial problems. He has received eviction notices, which had been forwarded to the hearing office but no response had been received.

If we were to ask claimant representatives to provide up-to-date information on their current caseloads, we would see similar heart-wrenching stories of people's lives in financial ruin and chaos. What do these real-life stories about individuals caught in the process tell us about the current situation at SSA?

1. Processing times have reached intolerable levels.

The average processing time for cases at the hearing level has increased dramatically since 2000, when the average time was 274 days.³ In the current fiscal year, SSA estimates that the average processing time for disability claims at the hearing level will be 535 days,⁴ nearly twice as long as in 2000. It is important to keep in mind that this is an “average” and that many claimants will wait longer. In addition, the average processing times at the initial and reconsideration levels have grown over the last ten years by about 20 days at each level, with some cases taking much longer.⁵

The current processing times in some hearing offices are striking, and much longer than the 535 days targeted by SSA in FY 2008. SSA statistics from December 2007 for its 144 hearing offices⁶ indicate that the average processing time at 43 hearing offices is above the projected average processing time. There is wide fluctuation, with some offices over 700 days. And even in those hearing offices below the average processing time, it is important to keep in mind that there will be many cases above the average and each of those cases represents an individual with disabilities who must wait for critical cash and medical insurance benefits.

SSA has worked hard over the last year to reduce the number of “aged cases” at the hearing level. During FY 2007, there were more than 60,000 cases that would have been pending 1,000 days or longer by the end of FY 2007. The SSA Office of Disability Adjudication and Review (ODAR) dramatically reduced this number to 108 cases at the end of FY 2007 and is now focusing on cases that have been pending 900 days or longer. There is still much work to be done since there were more than 135,000 cases pending 900 days or longer – nearly two and one-half years – at the beginning of FY 2008.⁷

The impact of the budget and staffing cuts in district offices also affect the processing times at the hearing levels. Representatives have reported that cases are sitting longer in district offices after requests for hearings are filed, often adding months – or years – to the processing time. In a case described above from Providence, RI, a claimant was still waiting in 2007 for an ALJ hearing where the request for hearing was filed by the claimant *pro se* in 2004. The request was timely sent to the hearing office but without the claims folder. The hearing office returned the file to the SSA district office, where the case sat for **more than two years**. The hearing request and folder were finally sent to the hearing office in January 2007 after an attorney became involved in the case and started to track what happened. The hearing office scheduled the case for an expedited hearing in view of the more than two year delay.

2. The number of pending cases continues to increase.

³ *Social Security Disability: Better Planning, Management, and Evaluation Could Help Address Backlogs*, GAO-08-40 (Dec. 2007)(“GAO Report”), p. 22.

⁴ *Social Security Administration: Fiscal Year 2009 Justification of Estimates for Appropriations Committees (“SSA FY 09 Budget Justification”)*, p. 6.

⁵ GAO Report, p. 20.

⁶ “National Ranking Report by Average Processing Time” for the month ending 12/28/2007.

⁷ *Plan to Eliminate the Hearing Backlog and Prevent Its Recurrence: End of Year Report, Fiscal Year 2007*, SSA Office of Disability Adjudication and Review (“ODAR Report”), p. 3. Available at: http://www.ssa.gov/appeals/annual2007_12_7.pdf.

In a recent report, the Government Accountability Office (GAO) noted that the hearing level backlog was “almost eliminated” from FY 1997 to FY 1999, but then grew “unabated” by FY 2006.⁸ The number of pending cases at the hearing level reached a low in FY 1999 at 311,958 cases. The numbers have increased dramatically since 1999, reaching 752,000 in FY 2008.⁹

However, even for hearing offices with a lower number of pending cases, the numbers do not tell the whole story. Because of the disparities between hearing offices, many claimant representatives have reported that SSA has been transferring cases from offices with high numbers of pending cases to offices with lower numbers where the hearings are held by video conference, if the claimant agrees. While this is understandable in a national program, it nevertheless means that claimants who live near hearing offices with lower numbers of pending cases will end up waiting longer.

3. Staffing levels have decreased which means a decrease in service.

Representatives have noted the loss of Administrative Law Judges (ALJs) and support staff in hearing offices around the country. Former Commissioner Barnhart had planned to hire an additional 100 ALJs in FY 2006 but due to cuts in the President’s budget request, she was able to hire only 43. The real impact of the burden on the current ALJ corps can be seen by comparing statistics from 1998 and 2006. In FY 1998, there were 1,087 ALJs available to conduct hearings. This number dropped to 1,018 in FY 2006, while the number of pending cases more than doubled.¹⁰

Whether there are an adequate number of ALJs may not even be the primary staffing issue in hearing offices. According to the GAO: “By the close of fiscal year 2006, SSA saw the highest level of backlogged claims and the lowest ratio of support staff over this period [FY 1997 to FY 2006].”¹¹ Productivity is not related solely to the number of ALJs, but also to the number of support staff. In 2006, the actual ratio of support staff to ALJs was 4.12. SSA senior managers and ALJs recommend a staffing ratio of 5.25.¹² The actual ratio represented a significant decrease, about 25 percent, from the recommended level, at a time when the number of pending cases had increased dramatically. It is also important to note that the number of pending cases older than 270 days was much lower when the support staff to ALJ ratio was higher (FY 1999 to FY 2001).¹³

The SSA LAE appropriation for FY 2008 will allow the Commissioner to hire 150 new ALJs and some additional staff. We are encouraged that his goal is to reach a level of 1250 ALJs by early FY 2009. However, sufficient funding to maintain an adequate number of ALJs and support staff is necessary in FY 2009 and future years to continue reducing the backlog.

4. Impact on service provided in SSA field offices.

⁸ GAO Report, p. 20.

⁹ SSA FY 09 Budget Justification, p. 6.

¹⁰ GAO Report, p. 31.

¹¹ GAO Report, p. 32.

¹² *Id.*

¹³ *Id.*

Under the current budget situation, people with severe disabilities have experienced long delays and decreased services provided in SSA field offices, which do not have adequate resources to meet all of their current responsibilities. "Over the past decade, the growth in the disability claims backlogs has coincided with a period of staff turnover and losses throughout the disability claims process."¹⁴ SSA staffing levels are at the lowest level since the SSI program began making payments in 1974.

- **Impact on disability claims.** Under the current SSA budget situation, we are concerned that delays will grow not only at the hearing level but also at the initial and reconsideration levels. A recent action taken by SSA demonstrates the scope of the problem. In June 2006, SSA was forced to direct all available resources to the processing of initial applications, and away from processing reconsideration level cases, when the initial application backlog became too high. The decision to redirect resources was caused primarily by the cut in the President's request for fiscal year 2006. In some states, this meant that reconsideration cases were not processed or were temporarily stopped,¹⁵ unless the claimant knew to notify the state agency of "dire circumstances."

- **Impact on post-entitlement work.** The accumulated staffing reductions have already translated into SSA's inability to perform post-entitlement work. Not surprisingly, with millions of new applications filed each year, SSA emphasizes the importance of processing applications, determining eligibility, and providing benefits. Once a person begins to receive monthly benefits, there are many reasons why SSA may need to respond to contacts from the person or to initiate a contact, known as "post-entitlement work." Generally, this workload does not receive the priority it should. Frequently, when SSA is short on staff and local offices are overwhelmed by incoming applications and inquiries, agency workers are necessarily less attentive to post-entitlement issues. For people with disabilities, this can discourage efforts to return to work, undermining an important national goal of assisting people with disabilities to secure and maintain employment.

One key example of post-entitlement work that has fallen by the wayside in the past is the processing of earnings reports filed by people with disabilities. Typically, the individual calls SSA and reports work and earnings or brings the information into an SSA field office, but SSA fails to input the information into its computer system and does not make the needed adjustments in the person's benefits. Years later, after a computer match with earnings records, SSA notices the person was overpaid, sometimes tens of thousands of dollars, and sends an overpayment notice to this effect to the beneficiary. These are situations where the individual is clearly not at fault. However, all too often, after receiving the overpayment notice, the beneficiary will tell SSA that he or she reported the income as required and SSA will reply that it has no record of the reports.

When this occurs, it may result in complete loss of cash benefits (Title II benefits) or a reduction in cash assistance (SSI). It also can affect the person's health care coverage. To collect the overpayment, SSA may decide to withhold all or a portion of any current benefits owed, or SSA

¹⁴ GAO Report, p. 30.

¹⁵ See GAO Report, p. 18.

may demand repayment from the beneficiary if the person is not currently eligible for benefits. Not surprisingly, many individuals with disabilities are wary of attempting to return to work, out of fear that this may give rise to the overpayment scenario and result in a loss of economic stability and potentially of health care coverage upon which they rely. As a result of this long-term administrative problem, anecdotal evidence indicates that there is a widespread belief among people with disabilities that it is too risky to even attempt a return to work, because the beneficiary may end up in a frightening bureaucratic morass of overpayment notices, demands for repayment, and benefit termination.

- **Impact on performing continuing disability reviews (CDRs) and SSI redeterminations.**

The processing of CDRs and SSI redeterminations is necessary to protect program integrity and avert improper payments. Failure to conduct the full complement of CDRs would have adverse consequences for the federal budget and the deficit. According to SSA, CDRs result in \$10 of program savings and SSI redeterminations result in \$7 of program savings for each \$1 spent in administrative costs for the reviews.¹⁶ However, the number of reviews actually conducted is directly related to whether SSA receives the necessary funds. For example, the number of CDR reviews in 2006 was reduced by more than 50%, due to the lower level of appropriations. Even though the great majority of CDRs result in continuation of benefits, the savings from those CDRs that result in terminations are substantial because of the size of the program and the value of the benefits provided.

- **New caseloads are added without providing the funds to implement these provisions.**

Over the past decade, Congress has passed legislation that added to SSA's workload, but did not necessarily provide additional funds to implement these provisions. Recent examples include:

- Conducting pre-effectuation reviews on increasing numbers of initial SSI disability allowances. SSA must review these cases for accuracy prior to issuing the decision.
- Changing how SSI retroactive benefits are to be paid. SSA must issue these benefits in installments if the amount is equal to or more than three months of benefits. The first two installments can be no more than three months of benefits each, unless the beneficiary shows a hardship due to certain debts. Many more cases need to be addressed because under prior law, the provision was triggered only if the past due benefits equaled 12 months or more. With the trigger at three months, it is likely that many more beneficiaries ask SSA to make a special determination to issue a larger first or second installment.
- New SSA Medicare workloads. SSA has new workloads related to the Medicare Part D prescription drug program, including determining eligibility for low-income subsidies, processing subsidy changing events for current beneficiaries, conducting eligibility redeterminations, and performing premium withholding. And beginning in FY 2007, SSA must make annual income-related premium adjustment amount determinations for all current Medicare beneficiaries for the Medicare Part B premium for higher income beneficiaries. SSA also makes the determinations for new Part B applicants.

¹⁶ SSA FY 09 Budget Justification, p. 18.

We were encouraged that in the recent Economic Stimulus Act of 2008,¹⁷ Congress recognized the added work that SSA will incur as a result of the legislation and appropriated an additional \$31 million to the agency for FY 2008.

Our recommendations regarding SSA funding. SSA must be given enough funding to make disability decisions in a timely manner and to carry out other critical workloads. Due to the serious consequences of continued funding of SSA's administrative expenses at inadequate levels, we strongly recommend that SSA receive \$11 billion for its FY 2009 LAE. This amount will allow the agency to make significant strides in reducing the disability claims backlog, improving other services to the public, and conducting adequate numbers of CDRs and SSI redeterminations.

In addition, we also urge you to separate SSA's LAE budget authority from the Section 302(a) and (b) allocations for discretionary spending. The size of SSA's LAE is driven by the number of administrative functions it conducts to serve beneficiaries and applicants. The funds for Title II LAE are ultimately paid out of the Social Security Trust Funds and general revenues reimburse the Trust Funds for LAE costs associated with the Supplemental Security Income (SSI) program. There is a simple solution to SSA's escalating funding crisis. Congress can remove SSA's administrative functions from the discretionary budget that supports other important programs. SSA's LAE would still be subject to the annual appropriations process and Congressional oversight.

II. OTHER RECOMMENDATIONS FOR IMPROVING THE DISABILITY CLAIMS PROCESS

In addition to SSA's budget needs, the CCD Social Security Task Force has additional suggestions for improving the disability claims process for people with disabilities. Many of these recommendations have already been initiated by SSA.¹⁸ We believe that these recommendations and agency initiatives, which overall are not controversial and which we support, can go a long way towards reducing and eventually eliminating the disability claims backlog.

1. Improve development of evidence earlier in the process.

For many years, CCD has supported full development of the record at the beginning of the claim so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Changes at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process. Emphasis on improving the

¹⁷ Pub. L. No. 110-185.

¹⁸ Commissioner Astrue announced a number of initiatives to eliminate the SSA hearings backlog at a Senate Finance Committee hearing on May 23, 2007. The 18-page summary of his recommendations is available at www.senate.gov/finance/sitepages/hearing052307.htm. An update on the status of the recommendations/initiatives is the subject of the *Plan to Eliminate the Hearing Backlog and Prevent Its Recurrence: End of Year Report, Fiscal Year 2007*, SSA Office of Disability Adjudication and Review ("ODAR Report").

front end of the process is appropriate and warranted, since the vast majority of all claims allowed are approved at the initial levels. Such changes also will benefit the significant percentage of claimants denied at the initial level who would meet the SSA disability criteria if their cases were properly developed but who abandon their claims and do not appeal.

Developing the record so that relevant evidence from all sources can be considered is fundamental to full and fair adjudication of claims. The adjudicator needs to review a wide variety of evidence in a typical case, including: medical records of treatment; opinions from medical sources and other treating sources, such as social workers and therapists; records of prescribed medications; statements from former employers; and vocational assessments. The adjudicator needs these types of information to make the necessary findings and determinations under the SSA disability criteria.

The key to a successful disability determination process is having an adequate documentation base and properly evaluating the documentation that is obtained. Often, claimants are denied **not** because the evidence establishes that the person **is not disabled**, but because the limited evidence gathered cannot establish that the person **is disabled**. Unless claims are better developed at earlier levels, proposed procedural changes will not improve the disability determination process. Unfortunately, very often the files that denied claimants bring to claimant representatives show that inadequate development was done at the initial and reconsideration levels by the state agencies. Until this lack of evidentiary development is addressed, the correct decision on the claim cannot be made.

Claimants should be encouraged to submit evidence as early as possible. However, the fact that early submission of evidence does not occur more frequently is usually due to many legitimate reasons beyond the claimant's control, including:

- State agency disability examiners who fail to request and obtain necessary and relevant evidence, including the failure to request specific information tailored to the SSA disability criteria;
- The failure of SSA and state agency disability examiners to explain to claimants or providers what evidence is important, necessary, and relevant for adjudication of the claim;
- Cost or access restrictions, including confusion over Health Insurance Portability and Accountability Act (HIPAA) requirements, prevent claimants from obtaining records;
- Medical providers who delay or refuse to submit evidence;
- Inadequate reimbursement rates for providers; and
- Evidence which is submitted but then misplaced.

A properly developed file is usually before the ALJ at the hearing level because the claimant's representative has obtained evidence or because the ALJ has developed the claim. Not surprisingly, different evidentiary records at different levels can easily produce different results on the issue of disability. To address this, the agency needs to emphasize the full development of the record at the beginning of the claim.

We have a number of recommendations¹⁹ that we believe will improve the development process:

- **Provide more assistance to claimants at the application level.** At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing application paperwork so that all impairments and sources of information are identified, including non-physician and other professional sources, in addition to physicians.
- **DDSs need to obtain necessary and relevant evidence.** Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. DDSs should update and improve their forms to specifically request necessary information. This should include collecting functional capacity information, which is generally obtained at the ALJ hearing level but less so at the initial levels. In addition, SSA has created some national forms to collect evidence, but they vary in quality. The situation is further complicated because some DDSs use their own forms, which also vary in quality. SSA should review its own national forms and DDS forms that are used to collect evidence, and set standards for state-specific forms to ensure higher quality.

The same effort should be made with non-physician sources (therapists, social workers) who see the claimant more frequently than the treating doctor and have a more thorough knowledge of the individual's limitations.

It also should be emphasized that all of these sources should be contacted for clarification to ensure that information is not misconstrued and that decisions are not made on apparent inconsistencies, when in fact, none exist.

- **Increase reimbursement rates for providers.** To improve provider response rates to requests for records, appropriate reimbursement rates for medical records and reports need to be implemented. This also will help to improve the medical expertise available to adjudicators for consultative examinations and for medical experts.
- **Provide better explanations to medical providers.** SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and ask for evidence relevant to the standard.
- **Provide more training and guidance to adjudicators.** Many cases that reach the appeals levels are reversed due to erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as the rules for: weighing medical

¹⁹ Our recommendations include those made by Linda Landry, Disability Law Center, Boston, MA, at the SSA "Compassionate Allowance Outreach Hearing for Rare Diseases" held in Washington, DC, on December 4, 2007. Her testimony is available online at: <http://www.ssa.gov/compassionateallowances/LandryFinalCompassionateAllowances2.pdf>.

evidence, including treating source opinions; the role of non-physician evidence²⁰; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings, which provide very useful guidance in many areas of disability evaluation and are to be followed by all disability adjudicators.

- **Improve use of the existing methods of expediting disability determinations.** SSA already has in place a number of methods, often under-utilized, which can expedite a favorable disability decision if the appropriate criteria are met. These include: “Quick Disability Determinations,” Presumptive Disability in SSI cases, and terminal illness (“TERI”) cases.

- **Improve the quality of consultative examinations.** In addition to increasing reimbursement rates, steps should be taken to improve the quality of the consultative examination (CE) process. There are far too many stories about inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant’s. This is wasted money for SSA and unhelpful to individuals, especially those who with low incomes, who do not have complete medical records documenting their conditions and who need a high quality CE report to help establish their eligibility. The regulations allow SSA to pay treating physicians to provide CEs, but they are rarely used in that capacity. SSA should explore ways to expand use of treating physicians to provide this information. Also, to ensure that its funds are being used as effectively and appropriately as possible, SSA should provide more oversight of the CE process, which is conducted by the state agencies.

Is there a “culture of denial” at the early levels of the process? Recent media reports have raised the issue of whether a “culture of denial” exists at the initial and reconsideration levels of the disability claims process because of the high denial rate at those levels, while a majority of cases appealed to the ALJ hearing level are allowed. We do not know of any specific written documents that encourage denials at the earlier levels, but there are several reasons, in addition to the high denial rate, why there is a perception that a “culture of denial” exists.

By law, SSA must review at least 50 percent of all favorable disability determinations made by the state agencies.²¹ However, there is no similar requirement for the review of denials. As a result, state agency disability examiners know that they will receive more review – and possible feedback – if they allow a claim, but not if it is denied. A key question is whether this process influences or makes it easier for a disability examiner to deny – rather than allow – a claim.

In addition, the state agencies are held to “standards of performance,” by which SSA measures their compliance with SSA regulations and policy.²² The “standards of performance” include processing time standards.²³ Because of the processing time levels, we believe that the state agencies are under pressure to cut short efforts to obtain medical information and to make decisions on cases with incomplete records.

²⁰ This evidence is often given little or no weight even though SSA’s regulations provide that once an impairment is medically established, all types of probative evidence, e.g., medical, non-physician medical, or lay evidence, will be considered to determine the severity of the limitations imposed by the impairment(s).

²¹ Sections 221(c)(3)(A)[Title II] and 1633(e)(2)(A)[SSI] of the Social Security Act.

²² 20 C.F.R. §§ 404.1640 to 404.1643.

²³ *Id.* § 404.1642.

Finally, there is great variation in allowance/denial levels among the state agencies. There are a number of legitimate factors for this variation, but it is possible that the “culture” in certain state agencies could lead to a higher level of denials. This is an area that should be more closely examined.

The above factors, alone or in combination, should be examined to determine whether they produce a leaning toward denial of cases at this initial stage in the review process.

In the Commissioner’s May 2007 backlog elimination initiatives, there are two efforts that relate to the issue of reconsideration denials. SSA’s Office of Quality Performance is reviewing 14,000 reconsideration denials, drawn at random over a one-year period from 15 state agencies that have low accuracy rates. The review began in September 2007 and will continue during FY 2008. The purpose of the initiative is to detect and correct erroneous reconsideration decisions, to make recommendations for addressing identified problems, and to eventually reduce the number of hearing-level appeals.²⁴ The results of this initiative will be informative.

Under another initiative, cases have been informally remanded to DDSs based on “scoring profiles” from the Office of Quality Performance. DDSs agreed to review about 20,000 paper cases and SSA estimated that approximately 20% of the cases would be allowed. The allowance rate has actually been much higher – about 54%. In FY 2008, SSA plans to send a total of 51,000 cases to the DDSs, with an estimated 10% allowance rate. If the DDS does not issue a favorable decision, the cases return to ODAR with more development and move to the front of the queue for scheduling.²⁵

2. Expand technological improvements.

Commissioner Astrue has made a strong commitment to improve and expand the technology used in the disability determination process. CCD generally supports SSA’s technological initiatives to improve the disability claims process, so long as they do not infringe on claimants’ rights. Many of these improvements will not only reduce delays, but also provide better service to the public, and do not require fundamental changes to the process. The initiative to process disability claims electronically has the prospect of significantly reducing delays by eliminating lost files, reducing the time that files spend in transit, and preventing misfiled evidence. Some of the technological improvements that we believe can help reduce the backlog include the following:

- **The electronic disability folder: “eDIB.”** The Commissioner is moving forward with development of the electronic disability folder, “eDIB.”²⁶ The electronic folder should reduce delays caused by the moving and handing-off of folders, allowing for immediate access by whichever component of SSA or DDS is working on the claim.

²⁴ ODAR Report, p. 10.

²⁵ ODAR Report, p. 4.

²⁶ ODAR Report, p. 6.

- **Electronic Records Express (ERE).** ERE is an initiative to increase the use of electronic options for submitting records related to disability claims that have electronic folders. Currently, registered claimant representatives are able to submit evidence electronically through the SSA secure website or to a dedicated fax number. The representative is given a barcode for the claim and the information in the barcode directs the information submitted to the claimant's unique electronic disability folder.

SSA plans to expand use of ERE to allow representatives the ability to view the electronic folder online and to receive notices electronically. A pilot is targeted to begin in June 2008.²⁷ Claimant representatives are very supportive of this expansion, as it will allow them to view the folder as soon as representation is obtained and will allow them to determine what additional evidence is needed in the claim or if submitted evidence is missing. Currently, claimant representatives receive CDs of files at different stages while cases are pending at the hearing level or they can request a CD from the SSA field office. However, requesting CDs causes more work for SSA workers and can lead to delays until they are received. Direct access to the secure website will eliminate both of these issues.

SSA also is working to allow the filing of appeals over the Internet.

- **Findings Integrated Templates ("FIT").** FIT is used for ALJ decisions and integrates the ALJ's findings of fact into the body of the decision. It is a "smart" decision-writing process, i.e., while it does not dictate the ultimate decision, it requires the ALJ to follow a series of templates to support the ultimate decision. The vast majority of ALJs are now using FIT to write their decisions. FIT is available to the public on SSA's website²⁸ and claimant representatives can use FIT to draft favorable decisions for ALJs. SSA is encouraging ALJs to accept draft decisions from representatives. Claimant representatives have reported problems with downloading FIT from the public website. These concerns have been relayed to SSA and we are hopeful that they will be resolved in the near future.

- **Use of video hearings.** The Commissioner is expanding the use of video hearings at the ALJ level. This allows ALJs to conduct hearings without being at the same geographical site as the claimant and representative and has the potential to reduce processing times and increase productivity. Claimant representatives have participated in hearings around the country and have reported a mixed experience, depending on the benefit for claimants, the quality of the equipment used, and the hearing room set-up.

We support the use of video teleconference hearings so long as the right to a full and fair hearing is adequately protected; the quality of video teleconference hearings is assured; and the claimant retains the absolute right to have an in-person hearing as provided under current regulations.²⁹

3. New screening initiatives.

²⁷ ODAR Report, p. 7.

²⁸ FIT can be downloaded from www.ssa.gov/appeals/fir.

²⁹ 20 C.F.R. §§ 404.936 and 416.1436.

We support efforts by SSA to accelerate the receipt of benefits for individuals with disabilities and support the agency's desire to develop new mechanisms to expand the population of claimants who may qualify for expedited eligibility throughout the application and review process. Ideally, adjudicators should use SSA screening criteria as early as possible in the process. However, we also encourage the use of ongoing screening as claimants obtain more documentation to support their applications.

Although we support expedited screening mechanisms, we urge caution so that any new eligibility criteria do not create unintended consequences for individuals who may qualify later in the process. In other words, we do not support any expedited screening process that may eliminate the ability of applicants to continue through the full sequential evaluation. For some claimants, a medical diagnosis may provide the objective evidence of their impairment. However, we express concern about any approach that may either inadvertently diminish the significance of functional evidence or overlook the substantial obstacles that a very large number of individuals face to obtain medical evidence to support their claims. In addition, SSA must work to ensure that there is no negative inference when a claim is not selected by the screening tool or allowed at that initial evaluation.

There are two initiatives that hold promise:

- **Quick Disability Determinations.** We have supported the Quick Disability Determination (QDD) process since it first began in SSA Region I states in August 2006 and was expanded nationwide by Commissioner Astrue in September 2007.³⁰ Under QDD, a computer screening tool identifies initial claims with a high likelihood of a favorable disability determination. The QDD process has the potential of providing a prompt disability decision to those claimants who are the most severely disabled. Since the QDD process's August 2006 implementation in Region I states, the initial QDD results have been very positive. In particular, we are impressed that the vast majority of QDD cases have been decided favorably in less than 20 days. Currently, the majority of cases referred for QDD processing involve cancer. However, Commissioner Astrue intends to expand the number and types of cases referred to the QDD process and we support this expansion.

- **"Compassionate allowances."** In July 2007, SSA published an Advance Notice of Proposed Rulemaking (ANPRM) on a proposed new screening mechanism for disability determinations to be known as "Compassionate Allowances."³¹ According to the ANPRM, SSA is "investigating methods of making 'compassionate allowances' by quickly identifying individuals with obvious disabilities." While there is no definition of disabilities that are considered "obvious," there is emphasis on creating "an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both...." Like the QDD process, SSA is looking at the use of computer software to screen cases by searching claims for key words in the electronic folder. An outreach hearing was held on December 4 and 5, 2007, regarding this initiative.³² We understand that additional hearings will be held.

³⁰ 20 C.F.R. §§ 404.1619 and 416.1019.

³¹ 72 Fed. Reg. 41649 (July 31, 2007).

³² For more information, see www.ssa.gov/compassionateallowances.

The CCD Social Security Task Force submitted comments to the ANPRM and we are generally supportive of this initiative so long as it does not eliminate the ability of applicants to continue through the full disability evaluation process. While recognizing that it is a laudable goal to expedite eligibility for individuals with terminal illnesses or other very serious conditions, we do not support a screening method that may create unintended consequences for individuals who do not meet the objective screening criteria and must collect documentation of their functional limitations.

In our comments to the ANPRM, we also made a number of specific recommendations for screening mechanisms including:

- A broader screening mechanism that goes beyond the existing “terminal illness” (TERI) process to include a wider range of claimants and publish criteria in the regulations;
- A preliminary, nonexhaustive list of impairments – affecting both children and adults – to consider for the new screening process;
- Strengthening SSA rules regarding the evaluation and weighing of VA disability ratings for veterans who apply for Title II or SSI disability benefits; and
- Applying the new expedited screening mechanism throughout the application and review process when file evidence indicates the claimant meets the criteria.

4. Other hearing level improvements.

- **The Senior Attorney Program.** In the 1990s, as an initiative to reduce the backlog of cases at hearing offices, senior staff attorneys were given the authority to issue fully favorable decisions in cases that could be decided without a hearing (i.e. “on the record”). This program was well received by claimants’ representatives because it presented an opportunity to present a case and obtain a favorable result efficiently and promptly. And, of most importance, thousands of claimants benefited. While the Senior Attorney Program existed, it helped to reduce the backlog by issuing approximately 200,000 decisions. The initiative was phased out in 2000, just about the same time that the backlog began to increase.

We are pleased that Commissioner Astrue has decided to reinstate the program for at least the next two years³³ and has proceeded with its implementation.³⁴ We believe that this initiative will help to reduce the backlog of cases at the hearing level as the prior program did during the 1990’s.

- **Increasing the time for providing notice of hearings.** Current regulations in most of the country provide only a 20-day advance notice for ALJ hearings. This time period is not adequate for requesting, receiving, and submitting the most recent and up-to-date medical evidence prior to the hearing. Some hearing offices, but not on a nationwide basis, do provide much longer

³³ The interim final rule reinstating the program was published in August 2007 and became effective on October 9, 2007. 72 Fed. Reg. 44763 (Aug. 9, 2007).

³⁴ ODAR Report, p. 3.

advance notice, some as long as 90 days. In SSA Region I states under the “Disability Service Improvement (DSI)” process, the time has been increased to 75 days, with the goal of providing adequate time to obtain new evidence (although, there is no requirement that providers, such as medical offices and hospitals, submit evidence within that time period).

SSA has proposed to expand the 75-day hearing notice requirement nationwide.³⁵ We strongly support this proposed change. This increased time period will mean that many more cases would be fully developed prior to the hearing and lead to more on the record decisions, avoiding the need for a hearing.

Caution regarding the search for efficiencies. While we generally support the goal of achieving increased efficiency throughout the adjudicatory process, we caution that limits must be placed on the goal of administrative efficiency for efficiency’s sake. The purpose of the Social Security and SSI programs are to provide cash benefits to those who need them and have earned them and who meet the eligibility criteria. While there may be ways to improve the decision-making process from the perspective of the adjudicators, the bottom line evaluation must be how the process affects the very claimants and beneficiaries for whom the system exists.

People who find they cannot work at a sustained and substantial level are faced with a myriad of personal, family, and financial circumstances that will have an impact on how well or efficiently they can maneuver the complex system for determining eligibility. Many will not be successful in addressing all of SSA’s requirements for proving eligibility until they reach a point where they request the assistance of an experienced representative. Many face educational barriers and/or significant barriers inherent in the disability itself that prevent them from understanding their role in the adjudicatory process and from efficiently and effectively assisting in gathering evidence. Still others are faced with having no “medical home” to call upon for assistance in submitting evidence, given their lack of health insurance over the course of many years. Many are experiencing extreme hardship from the loss of earned income, often living through the break-up of their family and/or becoming homeless, with few resources - financial, emotional, or otherwise - to rely upon. Still others experience all of the above limits on their abilities to participate effectively in the process.

We believe that the critical measure for assessing any new initiatives for achieving administrative efficiencies must be the potential impact on claimants and beneficiaries. Proposals for increasing administrative efficiencies must bend to the realities of claimants’ lives and accept that people face innumerable obstacles at the time they apply for disability benefits and beyond. SSA must continue and improve its established role in ensuring that an individual’s claim is fully developed before a decision is made and must ensure that its rules reflect this administrative responsibility.

On October 29, 2007, SSA published a Notice of Proposed Rulemaking (NPRM), which would make major changes to the appeals process.³⁶ The disability community and others registered significant concerns and opposition to major sections of the NPRM because of the impact the proposals would have on claimants and beneficiaries. As a result, Commissioner Astrue has

³⁵ 72 Fed. Reg. 61218 (Oct. 29, 2007).

³⁶ *Id.*

announced that he is withdrawing the controversial sections of the proposal and we believe that he and his staff are working in good faith to find alternative approaches which will not have negative impacts on claimants. We applaud Commissioner Astrue's efforts and have pledged to work with SSA to find such alternative approaches.

CONCLUSION

Thank you for the opportunity to testify today. For people with disabilities, it is critical that SSA be given enough funding to make disability decisions in a timely manner and to carry out its other mandated workloads.

We also support changes to improve the disability claims process so long as those changes do not affect the fairness of the procedures used to determine disability. For people with disabilities, it is critical that SSA receive adequate funding to carry out its mandated services and improve its process for making disability determinations.

On Behalf of:

**American Council of the Blind
American Network of Community Options and Resources
Association of University Centers on Disabilities
Council of State Administrators of Vocational Rehabilitation
Easter Seals, Inc.
Epilepsy Foundation
Goodwill Industries International
National Alliance on Mental Illness
National Association of Disability Representatives
National Disability Rights Network
National Industries for the Blind
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
Research Institute for Independent Living
The Arc of the United States
Title II Community AIDS National Network
United Cerebral Palsy
United Spinal Association**

Marty Ford is the Director of Legal Advocacy for The Arc and UCP Disability Policy Collaboration. She also serves as Chair of the Consortium for Citizens with Disabilities (CCD). She has over two decades of experience in federal public policy issues affecting people with disabilities. Ms. Ford represents both The Arc of the United States and United Cerebral Palsy on Capitol Hill and in the federal agencies on issues affecting people with disabilities in long term services and supports (including Medicaid), the Supplemental Security Income program, and Social Security disability issues. She serves as Co-Chair of the CCD Task Forces on Social Security and on Long Term Services and Supports. She is a member of the National Academy of Social Insurance and the American Bar Association.

Mr. OBEY. Let me explain what is happening. These votes have come earlier than we had expected, and they will probably take close to 40 minutes by the time everything is done, and they are the last votes of the week so everybody is going to be running to the airports. So you are going to get off easy, I think, in terms of not having to answer any questions.

I would like to get Mr. Bernoski's statement in yet if we can and if we have time for a couple questions before we have to go vote, we will slip them in. If not, you will get off early and easy, and let me thank you for coming.

Now, go ahead, Mr. Bernoski.

Mr. BERNOSKI. Mr. Chairman, thank you for inviting us to testify before this Subcommittee today.

Our organization represents the administrative law judges in the Social Security Administration, and we deal with the problems of the Social Security case backlog in our hearing offices on a daily basis, and it troubles us to see the American people waiting long periods of time for hearings on their claims.

Mr. Chairman, our judges have been working hard, and we have been rendering case dispositions in record numbers. For example, last year, we issued dispositions in over 550,000 cases for an average of over 40 cases a month per judge.

This is important to us because we are concerned with the long delays, but at the same time we must take enough time to provide a full and fair hearing to both the claimant and the government. It is important to the taxpayer that the proper claims are paid.

It should be noted that a study was done by the Agency in 1994 which concluded that if a judge devoted about 3 to 7 hours to a case, the judge would produce between 25 to 55 cases a month. We do not believe that 7 hours is too long to spend on a claim that may cost the trust fund \$250,000. As the evidence shows, we are working well within the top end of that range.

As we know, the funding is the life blood of programs in both the public and private sectors, and in the case of Social Security, it has been underfunded for the past years. The lack of funding has had a profound impact on the Agency, and it has been unable to hire sufficient staff and administrative law judges to handle the increasing number of disability claims that have been filed with our hearing offices.

In addition to hiring new support staff, we have made suggestions to the Agency to address this staff crisis by other means and to supplement the crisis. By example, we have suggested that the Agency recall retired administrative law judges from the existing OPM Senior Judge Register. These judges are trained and do not need a learning period to become productive for the Agency, and they also cost the Agency less money in salary.

Secondly, we suggest that the Agency employ retired Social Security workers on a contract basis. These retired employees are familiar with the work of the Agency and require little training.

And, third, we suggest that the Agency hire law school students as interns to help in decision-writing which remains a major weakness in our program.

However, I must emphasize that hiring judges without staff is not sufficient. Each judge requires, as the Commissioner indicated,

about four to five staff persons for assistance in support in hearing and deciding cases, and the Agency has not been replacing our staff on a one-on-one ratio as we have been losing them.

In the recent past, the Agency has attempted to shift some of the clerical work to judges, and this is counterproductive because it uses expensive employees to do clerical work which slows down the productivity of the judge and is very costly for the government.

Recently, we have noticed a definite tendency of the Agency to attempt to shift the blame for the disability backlog to the judges. In this regard, we note a December 2007 GAO report that stated that the backlogs have been a problem with the Social Security Administration for many years and that the contributing factors to the backlog include: one, an increase in applications; two, a loss of key personnel including administrative law judges; and, three, management weaknesses which is evidenced by the many failed reform initiatives that we had for the past 20 years or so.

In fact, in a recent disability roundtable hosted by our association, it was the consensus of the panel which included the Comptroller General of the United States, Mr. Walker, that no single group in the Agency is responsible for this backlog.

Now we are of the opinion that some basic or systemic reform is needed for the Social Security process, and these include adopting rules of practice and procedure for our judges.

Another is having the claimants' attorneys be brought into the process and serve as officers of the court. There is a tremendous pool of talent here that is available that the Agency should take advantage of.

And, third, by adding what we call a Social Security counsel to the process. This person would have many of the same responsibilities as the reviewing official had in SDI, and that was implemented by the former Commissioner Barnhart.

The objective is to create a system that pays the appropriate claim as early in the process as possible and only having the most difficult cases move on to hearing. That would address the issue raised by Representative McCollum earlier in the hearing, and also the Commissioner alluded to that also.

The goal is to reduce both processing times and the backlog. We can no longer afford to hear 90 percent of our cases and bring those to a full hearing. The cases that should be paid should be handled quicker in the process and to move our process along more smoothly.

Now this reform will cost some money, of course, because we have a very large system. We are the largest. Probably one of the largest governmental systems in the world is housed within the Social Security Administration. But, ultimately, it will have an impact, a beneficial impact on the American people.

Mr. Chairman, in closing, I just say that the Social Security disability program has significant systemic problems which need correction. We also need more funding for judges and staff. However, the systemic problems need separate legislation, and money alone is not enough.

We look forward to assisting Congress and this Committee in working on these changes.

As a matter on the systemic changes, we had prepared a paper in December of last year, a 24-page paper which we have disseminated as part of our roundtable and have given to the Social Security Subcommittees. I am not going to offer it as part of the record because it is 24 pages, but I will give it to you for your information.

I apologize for not making copies for other members of the Committee, but quite frankly I forgot, and I will send copies in the mail to everyone else on the Committee.

[The information follows:]

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**STATEMENT ON BEHALF OF THE
ASSOCIATION OF ADMINISTRATIVE LAW JUDGES**

By

RONALD G. BERNOSKI, PRESIDENT

Before the

**SUBCOMMITTEE ON LABOR, HEALTH AND
HUMAN SERVICES, AND RELATED AGENCIES
ON
COMMITTEE ON APPROPRIATIONS**

**Reducing the Disability Backlog at the Social Security Administration/
FY2009 Budget Overview**

February 28, 2008

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to provide this statement regarding reducing the backlog of disability cases at the Social Security Administration, Office of Disability Adjudication and Review. My name is Ronald G. Bernoski. I am an administrative law judge who has been hearing Social Security Disability cases in Milwaukee, Wisconsin, for over 27 years.

I also serve as President of the Association of Administrative Law Judges (AALJ), a position I have held for over a decade. Our organization represents the administrative law judges employed at the Social Security Administration and the Department of Health and Human Services. One of the stated purposes of the AALJ is to promote and preserve full due process hearings in compliance with the Administrative Procedure Act for those individuals who seek adjudication of program entitlement disputes within the SSA. The AALJ represents about 1100 of the approximately 1400 administrative law judges in the entire Federal government.

Funding is the life blood of all programs in both the public and private sectors. During the past five years the Congress has appropriated \$900 million less than the President had requested in his status quo budgets for Social Security. This lack of funding has had a profound effect on the capacity of the agency to hire sufficient numbers of administrative law judges and adequate support staff to service the increasing number of Requests for Hearings that are being filed with the adjudication component of the agency, the Office of Disability Adjudication and Review (ODAR). Further, because of inadequate funding, the agency has not been able to continue with the disability reforms begun by former Commissioner

Barnhart. The disability case backlog is now at critical levels with neither a sufficient number of administrative law judges nor critically important support personnel to meet the needs of the American people. With the disbanding of the Disability Service Improvement Plan (DSI), the agency has no effective plan to address this problem. Instead, it is in the process of retreating to the disability adjudication process that has not been fully effective for well over 20 years. At best, current SSA efforts to address the backlog amount to “tinkering around the edges” of this system. The result continues to be long case processing times and an unnecessary hardship for those Americans who find themselves in need of disability benefits. Set forth in its December 7, 2007 report on the disability backlog at SSA, the Government Accountability Office concluded that at the same time disability applications began to increase, “...SSA experienced losses of key personnel that included disability examiners and medical or psychological consultants in the DDS offices, and administrative law judges and support staff in the hearing offices.” The report further concluded that “...management weaknesses as evidenced by a number of initiatives that were not successfully implemented have limited SSA’s ability to remedy the backlog”

There are approximately 6500 employees in the Office of Disability Adjudication and Review. The judges make up about 15% of the employees. The remaining 85% are employed solely to support the judges who hear and decide claims. Indeed, the sole mission of the organization is to hear, adjudicate and review claims. This is true of the Chief Judge and his staff, all the Regional Chief Judges, all the regional office staff, all the hearing office staff and to some extent all the Hearing Office Chief Judges. Since more recently there has been considerable focus on the productivity of the line judges let me state a truism: The hearing process does not start and end with the judges. As Comptroller General David

Walker stated last month at a Roundtable on the Backlog sponsored by the AALJ, a complete systemic review of a Disability System that was designed 50 years ago is necessary.

No judge, no matter how talented and dedicated, can single-handedly prepare, hear and write 40 - 50 decisions per month, month in and month out. We must depend on adequate and competent staff and planning by the agency. Before appropriating additional funding the Congress and the American public have a right to know that the agency has planned to spend present funding and future funding efficiently and wisely. So hiring additional judges without also hiring sufficient staff support, we believe, is not a prudent use of scarce government resources. The Agency has announced plans to hire 175 additional judges without specifying how many additional staff are to be hired to support these new judges. Assuming \$125,000 salary and fringe benefits for a judge, the annual cost will be about \$22 million. Each judge needs 4-5 staff persons to prepare and process cases before and after the judge hears the case. The Deputy Chief in charge of ODAR has been quoted as saying the ratio should be 5.25 to 1. Our existing judges are already short hundreds of staff members. To hire 175 new judges without hiring the necessary staff is like buying 175 new trucks but only enough fuel to operate 20 of those trucks. Under these circumstances, the average productivity per truck or per judge can only decline. This is clearly not the way to manage the present crises. What business would make such a decision?

Here are some other recent examples of questionable use of Agency resources as reported from our constituents in the field hearing offices:

The Agency has publicized it was paying for 30,000 hours of overtime by field office, non-ODAR, SSA employees to perform backlogged ODAR work on the weekends. These field office employees had to be trained to work for four hours of overtime. However, the training went for naught. The next weekend a different group was assigned to work four hours and once again had to be trained. We have advocated that SSA rehire, on an hourly basis, recently retired Senior Case Technicians, who are highly experienced, to actually help reduce the backlog. We believe that SSA paying for 30,000 hours of overtime to inexperienced people at time and a half, rather than rehire highly experienced people at straight time is merely throwing money at the problem. We believe that overtime for the present ODAR staff should be reserved for our very best and most productive staff members.

We have also learned that a judge being transferred from California to Oklahoma had about 50 cases in post-hearing status, meaning the hearings had already been held. He wanted to take the cases with him to work on in Oklahoma. Someone in the Dallas region told the San Francisco region they were refusing to accept the 50 cases. The 50 cases had to be reassigned to other judges in California for new hearings. The 50 claimants involved had to wait another 2-4 months for a decision; the California judges had to prepare for and hear 50 new cases and ODAR had to pay for another 50 hearings. This is not prudent management.

We were able to obtain the production figures for the Decision Writers in Miami. The approximately 10 decision writers in Miami drafted 91 decisions in December 2007 and 121 in January 2008. Based on Agency guidelines of taking four hours to draft a favorable decision and 8 hours to draft an unfavorable, each decision writer should have drafted 24 favorable decisions and 6 unfavorable decisions for a total of 30 each month. This should have resulted in a total of 600 drafts in two months rather than 212. The ten judges in Miami drafted more decisions than the decision writers in both months.

The agency recently announced it had modified the Findings Integrated Template (FIT) so that a judge could write a fully favorable decision in less time than it would take to write decision instructions which would mean less than one hour. However, if this is true, why are decisions writers still given four hours to draft a fully favorable decision?

We could give other examples. However, agency management reports are SECRET. We can think of no reason for this obsessive secrecy. We believe the American public and Congress would be better served with a management system that was completely transparent.

In a 1994 reform initiative known as the *Plan For A New Disability Claim Process*, the agency completed a time line for a disability claim at all levels of the disability process, including the administrative law judge hearing. The study concluded that an administrative law judge could reasonably be expected to devote from 3 hours

and 10 minutes to 7 hours on a case. This included time devoted by a judge from the initial pre-hearing review of the file to the final review and signing of the decision. When considering the work time available in an average month (4 1/3 weeks), a reasonable case disposition rate for a judge, based on this agency study, would be in the range of 24.7 to 54.7 cases per month. The study was based on the staff performing all the functions in their position descriptions to support the judges, including:

- Reviews and analyzes the case to ensure sufficiency of evidence or documentation, and to ensure that the case is ready for hearing.
- Prepares case summaries by outlining, in narrative form, information from all documents which reflect the prior medical history of the claimant and treatment undertaken, and any conflicting medical evidence. Also outlines case development taken on own initiative. This involves a close scrutiny of the medical evidence, treatment and treating sources so that the ALJ is fully cognizant of diagnoses and all areas of medical treatment provided the claimant. Points out discrepancies in factual issues that should be addressed at the hearing.

In a management decision ten years ago all the above functions in support of the judges were waived by the agency due to the then backlog crises *de jure* and the staff was directed to simply place the exhibits in reverse chronological order and number the pages with no review, no analysis and no case summary. This is how the Agency has been operating for the last ten years in a constant crises mode. This method of management has continued and the agency has responded to the latest backlog crises in the same manner. It has further waived clerical functions and shifted these functions totally to the judges by having the staff simply dump all the paperwork into a folder without sorting it for duplicates, without placing the evidence in reverse chronological order, and letting the judges sort it out. We used

to call this a “junk folder.” Now the agency touts it as a “streamlined folder” and lists it as one of the cornerstones for eliminating the backlog.

Last year, despite the lack of full staff support at the front end of the hearing process, administrative law judges at Social Security issued determinations in over 550,000 cases with an average monthly disposition rate of over 40 cases per judges. These production statistics clearly establish that the administrative law judges at Social Security are working hard and that we are issuing determinations at levels which are at the high end of the agency’s own expectations. It is also important to note, that while a case may be in ODAR for a year or more, the administrative law judge probably has the case in his/her possession for a period of only 3 hours 10 minutes to 7 hours. We suggest that it is not excessive to devote 7 hours to a claim that may cost the Social Security trust fund up to \$250,000.00, including Medicare benefits.

No one can gainsay that a judge needs a fully developed record to provide a proper due process hearing to a claimant. Former Commissioner Jo Ann Barnhart recognized that in DSI. She admitted it would require additional work at the front end but would in the long run speed up the entire process since the judges would be provided with a fully developed record at the beginning of the hearing process prepared by an attorney who had the primary responsibility of developing the record for the administrative law judge hearing or awarding benefits “on the record,” where appropriate. The Association of Administrative Law Judges worked cooperatively with Commissioner Barnhart in support of the DSI plan. It appeared that SSA had finally righted itself. DSI was on the correct track. DSI was a long term solution that was fully developed for testing and a phased in implementation. However, this reform was almost immediately abandoned by her

successor without an adequate "pilot" to test its effectiveness. The rejection of DSI is a severe blow to addressing the backlog. We believe that this was a worthwhile effort to attack the backlog. We are back to square one after five years of planning and partial implementation in Region 1. We are once again faced with the judges having to develop the record. If there is one thing we have learned in the ten years that the agency has waived the most important functions performed by the staff in developing the record, it is that the American public should not be paying judges \$150,000 per year to be super-clerks. Judges should be hearing and deciding cases. As former Commissioner Barnhart correctly determined, someone else should be developing the record.

Currently about ninety percent of the claimants are represented at the hearing level. The Social Security Administration should adopt comprehensive rules of practice and procedure designed to promote efficiency in the hearing process. At our urging, the agency adopted some procedural rules with the implementation of DSI. However, we believe that additional procedural rules are necessary, except for *pro se* claimants, to maximize our efficiency. Most judicial systems have separate rules for *pro se* parties. Our judges are most willing to assist *pro se* claimants in developing their hearing records. When the hearing process was designed fifty years ago almost all claimants appeared *pro se*. The agency rejected our recommendations to have separate rules for *pro se* claimants and represented claimants by maintaining the existing regulations with regard to *pro se* claimants but not adding new comprehensive rules for represented claimants. The agency has now backed away from what we considered very important procedural and practice rules to make the hearing process more efficient and less costly in both time and money to the claimants and the American public.

Claimants' representatives receive \$1 Billion annually in fees from the past due benefits of successful claimants. Claimant representatives should be considered to be "officers of the court", in the manner customary in the American judicial system. They should be required to develop the record as any attorney is required to develop the record in all other judicial systems. The claimants are in the best position to know what medical evidence is available. Under present agency regulations representatives are only required to submit evidence favorable to the claimant's claim. We believe that all relevant and material medical evidence surrounding the claim should be part of the hearing record. This will permit the administrative law judge to provide a "full and fair" hearing for both the claimant and the government and make a decision based on the evidence of record.

Although the disability hearing process was designed fifty years to be informal, it is now a large process with an extremely accomplished bar representing the claimants. As a carry-over back to the informal nature of this system, SSA Judges still hear about 90% of all cases. No other judicial system tries this high a percentage of cases. The Federal Article III judges try only a very small percentage of the cases filed in their courts. We need to change the system so it is more efficient and we can grant benefits to worthy claimants as early as possible in the process. The creation of a Social Security Counsel position, an attorney, who could represent the Government in the ninety percent of the hearings where the claimant is represented and act as an ombudsman to assist the claimant in *pro se* cases would go a long way toward making the system more efficient. The Social Security Counsel would have the authority to narrow the issues, assist *pro se* claimants in developing their cases and recommend on-the-record decisions to the judge thereby avoiding the trial of many claims or having a short hearing limited to one or two issues. The objective of this change is to award benefits on appropriate

claims as early in the process as possible. The goal is to help claimants by reducing case processing times and case backlogs.

As above noted, the world's largest adjudicatory system has significant systemic problems which need to be corrected by this Congress. However, and as also noted above, this system has been under funded for many years. We need more judges and staff. Additional funding to accommodate this additional hiring, if properly managed, will have a significant impact of the disability backlog. The systemic problems need to be addressed by separate legislation. We would be happy to provide the Committee with our views on the nature and scope of such legislation.

Respectfully submitted,

Ronald G. Bernoski
President

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Mr. OBEY. All right. Thank you.

We have about six minutes before the clock expires.

Because Mr. Ryan hasn't asked any questions yet, let me just yield to him to see if he has a question he would like to ask.

Mr. RYAN. I appreciate it, Mr. Chairman. I just have one comment.

Mr. Warsinskey is from the great State of Ohio and from Cleveland, and he is the office that we work with. I just want to say what a phenomenal job you do.

Mr. WARSINSKEY. Thank you.

Mr. RYAN. We know you are in very difficult circumstances but a total class operation. You guys are truly professionals, and we know how hard it is because we are part of the front line of defense there in the Congressional offices, but we appreciate it and thank you very much for your service.

Mr. WARSINSKEY. Thank you.

Mr. OBEY. Mr. Walsh.

Mr. WALSH. Mr. Chairman, given what you said regarding the schedule, I am going to yield whatever time I have back, but I would just like to ask that Judge Bernoski's report be allowed to be entered into the record of the hearing.

Mr. OBEY. Sure.

Mr. WALSH. I thank you very much.

Thank you, witnesses, all.

Mr. OBEY. I have six or seven basic questions which I had wanted to get in. We will just have to get them to you, and you can respond in writing. If you would do that, please, I would appreciate it.

I apologize for the truncated nature of the hearing. We had to push it along in order to try to get everybody on the record. I appreciate your taking the time, and I appreciate the work you do.

Mr. BERNOSKI. Mr. Chairman, the Commissioner also raised several points if we could respond to in our written comments with relationship to the electronic file, the disciplining of judges and our relationship to the staff and our policy with staff.

Mr. OBEY. I would be happy to see that.

Mr. BERNOSKI. Okay. Thank you very much.

Mr. OBEY. Okay. Thank you very much.

[The following questions were submitted to be answered for the record:]

ADMINISTRATIVE BUDGET

Mr. Obey: Your message introducing your budget request says that the problems and shortfalls affecting SSA are a result of limited resources, increased demand for your core services and new responsibilities. To what extent are these problems due to limited resources, how much are due to increased demand for services, and how much are due to new responsibilities?

Mr. Astrue: Our budget problems are really due to a combination of the factors mentioned above. The administrative budget of the Social Security Administration (SSA) has grown annually by a little over 4 percent in the past 5 years, while inflation has caused costs to grow by an average of 5 percent each year. Increases in SSA's fixed costs, such as rent, guards, and employee salaries and benefits, have outpaced the growth in our appropriation, resulting in declining service to the public and large backlogs.

At the same time as inflation increased costs, SSA's core workloads also grew substantially and are expected to continue to do so. Over the next 10 years, SSA's traditional workloads will increase significantly – retirement claims by over 40 percent and initial disability claims by nearly 10 percent. SSA also continues to face many new complex responsibilities, from helping with the Medicare Prescription Drug Program to employment verifications needed for immigration reform.

The challenges SSA has faced in recent years have led to increased backlogs and have made it difficult for the Agency to maintain a high standard of customer service. However, the situation would be even worse now without the productivity improvements we have achieved or the excellent management that has benefited our programs. As an Agency, we take pride in making efficient use of our administrative resources. With administrative expenses of less than 2 percent of total program outlays, SSA is an excellent investment.

REDUCING THE HEARINGS BACKLOG

Mr. Obey: Under your current plan, the disability hearings backlog would not be cut to a manageable level until 2013. Why will it take so long to reduce the disability backlog? I understand that you want to make sure that you can sustain permanent staff, but have you considered the use of temporary measures, such as bringing back retired ALJ or support staff, for a shorter-term but concentrated effort to reduce the backlog?

Mr. Astrue: The hearings backlog started in 2001 and has taken 7 years to grow to its present level. There is no quick fix to the problem. The Hearings Backlog Reduction Plan was based on an assumption of reasonable resources through 2013. With additional funding beyond the assumed level and sustained throughout each year of our effort, we would be able to do marginally better. In order to handle the backlog in only a few years, we would have to almost double the size of our existing Administrative Law Judge (ALJ) corps, support staff and space. The training initiatives for such a large number of new hires would utilize many of our existing resources and would in fact slow our progress toward reducing the backlog. We would be left with an infrastructure of

space and staff that would go well beyond our needs and which would take years to attrit down to sustainable levels.

We believe that implementing the initiatives in the Hearings Backlog Reduction Plan will eliminate the backlog by 2013, and will permit us to maintain reasonable staffing and pending levels without requiring us to over-hire in these early years. Our plan uses a combination of initiatives to reduce the number of pending cases, including increased adjudicatory capacity, automation initiatives, and improved business process procedures.

In the interim, we are using all the temporary measures available to us. Over the last two years, we have brought back retired ALJs as rehired annuitants. These ALJs are already trained and have been able to make a significant contribution without the investment of resources into additional training. The senior attorney program and remands to the Disability Determination Services (DDSs) have provided decisions to claimants earlier, while leaving ALJs to concentrate on the more difficult cases that require a hearing. In fiscal year (FY) 2007, the DDSs issued 8,714 additional fully favorable decisions. In FY 2008, so far DDSs have processed 14,568 cases, making 5,042 fully favorable decisions. During this same period, senior attorneys have issued 7,325 dispositions. Agency operations staff have used overtime to handle a number of the tasks performed by hearing office support staff, adding resources to the front end process that moves the cases to ALJ dockets. We are also streamlining our case preparation process at the hearing level to increase the number of cases scheduled for hearing. These initiatives are a concentrated effort that is paying off in earlier and increased dispositions.

In October 2007, we opened the National Hearing Center (NHC). This hearing office handles only disability cases in electronic format. Hearings are held with video technology. Cases from areas of the country with high pending caseloads will be transferring workloads to this hearing center. Currently, the NHC has a little over 1,300 cases pending from Cleveland, Atlanta, and Detroit.

OPTIMAL HEARINGS PROCESSING TIME

Mr. Obey: Under your FY 2009 request, processing times for hearing decisions would be cut by only 29 days from 535 to 506 days. That means that the waiting time for a decision will still be nearly 17 months. I would be interested in what you consider to be an optimal processing time for these hearings? When will you reach that goal?

Mr. Astrue: We believe that the optimal average processing time for hearings is 180 to 270 days for most cases. Claimant advocates and attorneys tell us that claimants need time to find and retain attorneys, and attorneys need time to prepare for cases. The estimate of optimal processing time takes into consideration the time claimants and their representatives need to prepare their cases for a hearing.

For the past two years, we have been working diligently to eliminate our oldest pending cases. In fiscal year (FY) 2007, we identified 63,770 cases that would be over 1,000 days old at the end of the fiscal year. By the end of the fiscal year, we had issued dispositions in all but a handful of those cases. For FY 2008, our goal has been more ambitious. We identified 135,160 cases that would be 900 days old by the end of the fiscal year and have been working to issue dispositions in those cases. We have

reduced that number by over half and had only 61,218 of these cases pending at the end of February 2008. Handling these older cases has elevated our processing times in the short term; however, we are willing to accept this because we believe that putting these older cases first is not only the right thing to do for the people we serve but the only way to permanently reduce average processing time. As we resolve these older cases, average processing times should begin to fall dramatically. When the backlog is eliminated in 2013, we expect to have reduced our processing times to the 180-270 day range discussed above with an average pending per Administrative Law Judge of 360 cases, the number required "in the pipeline" for smooth operation.

COMMISSIONER'S BUDGET

Mr. Obey: I would like to get more detail on the record regarding the Commissioner's budget request that you submit to Congress. As I understand it, your budget proposes an additional \$100 million for administrative resources. Can you detail what you would do with these additional resources?

Mr. Astrue: My fiscal year 2009 budget for the administrative expenses of the Social Security Administration (SSA) is \$10.536 billion, a difference of \$76 million from the President's Budget (\$68 million for the Limitation on Administrative Expenses, \$4 million for the Office of the Inspector General, and \$4 million for research).

The President's budget provides less funding for SSA's information technology than my request. Further, it shifts some workload processing priorities from program integrity to disability. At the time I submitted my budget to the Office of Management and Budget, it appeared the Congress was still planning to approve dedicated program integrity funding for SSA, which would require a certain number of continuing disability reviews and Supplemental Security Income redeterminations. I straight-lined these workloads, rather than increasing or reducing them. By the time the President's budget was released, Congress enacted an appropriation for SSA that did not contain dedicated program integrity funding.

SSA believes the President's budget provides a fiscally responsible and reasonable approach that allows for substantial progress, while recognizing that years of limited funding and growth in disability backlogs and waiting times cannot be undone in 1 year.

OTHER WORK AND SERVICES IN SUPPORT OF THE PUBLIC

Mr. Obey: As I indicated in my opening remarks, for the first time in 15 years, Congress not only appropriated the President's 2008 budget request, but also provided an additional \$150 million to address the disability hearings backlog. In addition, we provided \$31 million in the stimulus package to ensure that the administrative tasks necessary to ensure that retirees have the documentation they need to obtain the rebate payments they are eligible for under the stimulus plan.

However, in dedicating resources to addressing disability backlogs, your budget shows consequences elsewhere. Other than for hearings, your budget justification indicates that SSA will essentially maintain the same level of services in other critical areas, and the backlog of what you call "other work and services in support of the public" will actually grow. Can you provide us with information on these other services? Will

you be able to replace staff in field offices, teleservice centers, and payment centers? Will improvements in the areas of the agency that are most visible to the public have to wait until after 2013 to be addressed?

Mr. Astrue: Although the President's Budget for the Social Security Administration (SSA) includes resources to maintain service in many areas, we would not be able to address every workload issue. For example, critical backlogs in workload components will grow by over 3,300 workyears in fiscal year (FY) 2008 and by about 4,800 workyears in FY 2009. It will be necessary for SSA to delay processing post-entitlement related actions, such as overpayments, underpayments, benefit suspensions and benefit reinstatements.

With the President's Budget, we will be able to maintain level staffing by replacing any losses in FY 2009 in field offices, teleservice centers, and payment centers. This is a major accomplishment since in recent years SSA staffing levels have declined. At the same time, we are looking at ways to conduct business more efficiently. The budget includes funding for information technology improvements that will improve productivity and service to the public.

Although we are focusing on reducing the disability backlogs, we still are making improvements wherever we can, whether it be a new telephone system to better serve the public or improved on-line services. Sustained, adequate funding will help SSA to improve service to the public in other key areas earlier than 2013.

DISABILITY DETERMINATION SERVICES ATTRITION RATE

Mr. Obey: In looking at the issue of staffing levels at SSA, one element that I found of interest was the fact that the attrition rate in the Disability Determination Services (DDSs) is nearly double that for Federal Government employees.

Given that staffing and training of disability examiners at the State level is such a crucial part of the overall integrity and effectiveness of the processing of disability claims, what is SSA doing to work with the States to address this problem?

In a 2004 report, the Government Accountability Office (GAO) criticized SSA for not having a strategic human capital plan that addresses current and future DDS human capital needs. What has been done since the GAO report to respond to these findings, including the recommendation that SSA use its authority to establish uniform human capital standards, such as minimum qualifications for examiners, to address some of the DDS challenges on a nationwide basis?

Mr. Astrue: The Social Security Administration (SSA) acknowledges the need for a qualified stable workforce and is making efforts to address the high attrition rate in the Disability Determinations Services (DDSs). The Office of Disability Determinations sponsored a recruitment and retention workgroup to identify the specific issues contributing towards the high attrition rate present in the DDSs and a strategy for reducing it. The workgroup's report outlines specific initiatives to deal with the issues identified and are currently being implemented by the Agency. Training investment and succession planning are considered as part of the long-term strategy.

Some of the actions the SSA has taken to date include creating standardized position descriptions that facilitate reclassification of employees to needed positions, allowing more flexible hiring even during a continuing resolution, establishing a Request for Program Consultation process to clarify policy application on difficult cases, and providing updated training manuals and Interactive Video Tele-training on medical listings and other related issues. The Agency has also capitalized on technology by using electronic systems development to provide some immediate relief. Additionally, the workgroup report developed a suggested implementation strategy to capture national exit survey data, prepare an executive marketing package for State and Federal officials, and developed a more competitive salary structure for DDS adjudicative positions. The report also reviews the consideration of national certification and a review of the State and Federal regulations that may support these activities.

SSA's ability to improve staffing at DDSs is limited by our relationship with the States, which operate them. Although SSA funds the DDSs, their operations are also subject to State policies. When hiring new employees, DDSs require not only hiring authority from SSA, but also from the State, which may not have an available vacancy. To minimize the disruption caused by reduced staffing, I provided the DDSs with year-round hiring authority. This ensures that when a DDS is ready to hire, it has the authority it needs from the Agency.

APPROVAL/DENIAL RATES

Mr. Obey: In response to a question, you provided an estimate of the percentage of claims denied at the initial determination level that remained denied at the end of the appeals process. I believe that number took into account the large number of cases that are not appealed. Of the numbers of cases that are appealed to the Federal level, can you provide a percentage that are ultimately approved at some stage of the appeals process, and those that remain denied when all appeals are exhausted?

Mr. Astrue: Recent experience shows that only about 33 percent of cases that were initially denied by the State Disability Determination Services (DDSs) were appealed to the Federal level (a hearing before an Administrative Law Judge and beyond). Including allowances, this represents only about 20 percent of all initial DDS decisions. Approximately 70 percent of these appealed cases ultimately resulted in an allowance and the remaining 30 percent ultimately resulted in a denial.

Absent significant change to the way disability is determined in our system, there will always be higher allowance rates at the Federal level. The pipeline of cases that get that far is narrower, and the more clear-cut allowances and denials are generally winnowed out. The hearing process gets the hardest, "gray area" cases. The time that passes between the initial decision and the hearing can result in factors that would increase the likelihood of an allowance, such as worsening in the claimant's medical condition, additional medical treatment, additional evidence obtained by the claimant's representative that was not available to the DDS, and changes in vocational factors such as increasing age (since we consider the claimant's age at step 5 of the sequential evaluation process, increased age alone (without any worsening of the medical condition) can result in an allowance). In addition to these factors, legal representation and the face-to-face aspect of a hearing result in higher allowance rates. However, despite the relatively high allowance rates for these, our most difficult cases, only about

25 percent of those approved for disability benefits were approved at Federal levels of appeal.

Mr. Obey: The performance information in your budget states that 97 percent of the decisions made at the State level by the Disability Determination Services on initial claims are accurate. Yet, I understand that more than 60 percent of the cases that are appealed are eventually approved for benefits. What can you tell us about the primary reasons that so many appeals are ultimately successful, and based on those reasons, what SSA is doing to improve the front end of the disability process?

Mr. Astrue: It is important to recognize that the initial Disability Determination Services (DDS) decision to allow or deny holds as the final decision over 80 percent of the time. The hearing process is a completely different process. There are face-to-face meetings, allowing for the opportunity to interact with the claimant and see impairments firsthand. Furthermore, the beneficiary often has a representative who has ensured that all conditions are documented and all medical evidence is available. Since time has passed before a hearing, new evidence also may be available if a condition has deteriorated or new impairments have developed. Factors that could favor an allowance include additional medical treatment, additional evidence obtained by the claimant's representative that was not available to the DDS, and changes in vocational factors such as increasing age (since we consider the claimant's age at step 5 of the sequential evaluation process, increased age alone (without any worsening of the medical condition) can result in an allowance). Therefore, a correct initial denial decision often becomes a correct allowance decision at a hearing.

The Social Security Administration (SSA) is making significant changes to improve the front end of the disability process. Efforts such as our new Quick Disability Determination (QDD) and Compassionate Allowances processes will improve service to the public, helping claimants to receive decisions earlier at this critical juncture in their lives. QDD was designed to identify and expedite claims that are likely to be allowed. It uses an electronic screening tool/predictive model to identify claims where there is a high probability that the claimant is disabled and where medical evidence can be easily and quickly obtained. Compassionate Allowances is an initiative to quickly identify diseases and other medical conditions that invariably qualify under SSA's medical listings based on minimal medical information. We are expediting the review of our medical regulations and medical listings. We have an ambitious effort underway to expand the medical listings to include, for the first time, many rare diseases and conditions. This effort will provide better guidance to adjudicators for these error-prone cases.

SUPPORT STAFF FOR ADMINISTRATIVE LAW JUDGES

Mr. Obey: Judge Bernoski's testimony points out the need for adequate staff support for ALJs. Can you elaborate on your plans to hire additional attorneys, decision-writers and support staff necessary to ensure that the 175 additional judges that are at the core of the disability backlog plan have the resources needed to efficiently process cases? Can you discuss the appropriate ratio of support staff to judge, and what you need to do to get to that level?

Mr. Astrue: Since I began as Commissioner, I increased the number of support staff per Administrative Law Judge (ALJ) from 4.1 to 4.4. The number of staff needed to

support a disposition will change as we fully implement the backlog plan, but at the moment that number is difficult to project with any certainty. There are several reasons. We are currently in a transition from a paper environment to a fully electronic environment—a transition which started several years ago and will continue for several more. We know that automating many of our clerical functions will reduce the amount of time spent by staff on more routine tasks, and allow them to absorb additional workload. We are also working to standardize our business process, which should result in additional staff efficiencies. We will continue to monitor the appropriate staff-to-judge ratio as the new processes are implemented.

ADMINISTRATIVE LAW JUDGE PRODUCTIVITY

Mr. Obey: Commissioner, you've testified that there are some judges whose production is low. How widespread is this problem?

Mr. Astrue: Approximately 26 percent of the Administrative Law Judge (ALJ) corps makes fewer than 400 dispositions a year. If every ALJ produced at least 500 dispositions a year, we would have 65,000 more dispositions a year.

GOVERNMENT COUNSEL FOR HEARINGS

Mr. Obey: What do you think of the AALJ's suggestion that there should be government counsel to help develop the record for the ALJ?

Mr. Astrue: The Association of Administrative Law Judges (AALJ) has suggested government counsel before as part of its proposal that hearings held by the Social Security Administration (SSA) should be adversarial. That model is inconsistent with the established nature of SSA's hearings and would require an entirely new reading of the Social Security Act. Appointing opposing counsel to defend opposing views makes sense once the Agency has taken final action, but until an Administrative Law Judge (ALJ) issues a decision, there is no final Agency position to argue, support, or defend.

It is well established under the Act that the ALJ has the duty to investigate the facts and develop the arguments both for and against granting benefits. Staff support for ALJs includes staff designated to develop the record in accordance with the ALJ's instructions.

In the 1980s, the Agency implemented a pilot project using government advocates. The District Court in *Salling v. Bowen* deemed the project unconstitutional, and the Agency was permanently enjoined from continuing the project. Most notably, the Court concluded the use of the government advocates threatened the independence of the ALJs, contravened the non-adversarial nature of disability hearings, and violated the intention of the Social Security Act itself.

Establishing government counsel to develop the record and represent the Agency in every case at the hearing level would require an enormous infusion of resources. We also note that the AALJ has provided no evidence that an adversarial process would result in better, timelier decisions.

REPLACEMENT OF LOST OR STOLEN CHECKS

Ms. Roybal-Allard: Last year a constituent of mine reported to the Los Angeles Social Security Field office that two months of his Social Security checks were stolen. After nine months of non-response he asked my district office to intercede, and they repeatedly contacted the SS field office. None of my staff's calls were returned and in the end, it took over a year for the stolen checks to be reissued. My constituent had suffered immensely from what amounted to essentially the withholding of two months salary.

Is the case I just described a standard amount of time for lost or stolen checks to be reissued to someone who depends on this income for daily existence?

Mr. Astrue: I can assure you that this case is not representative of our efforts to respond to beneficiary requests. The standard time for issuance of replacement checks is 7-10 days. If a beneficiary is in dire need, he or she can go to the local field office for an immediate payment.

Ms. Roybal-Allard: Was the fact that my District Office did not receive a call back from the field office indicative of the understaffing in the field offices?

Mr. Astrue: In general, Social Security Administration employees make every effort to respond to inquiries from the public. However, delays can occur, and understaffing in field offices is a major reason for delays in handling workloads.

Ms. Roybal-Allard: How do you think the administrative process could be streamlined to ensure that checks are reissued in a timely manner and that Congressional offices receive more reasonable feedback?

Mr. Astrue: The current process for reissuing checks works very well. Since our payments are made by Treasury, there is a delay of 7-10 days for replacement checks. Also, paper checks are inherently slow and are prone to delays due to theft and bad weather, therefore we recommend direct deposit. Payments made by direct deposit can be replaced in 3 days. The current process allows for immediate payments to be made in dire need situations.

Our current procedure requires priority handling of congressional inquiries. The case described does not reflect our standard practice and is an isolated incident.

FULL-TIME EQUIVALENTS AND ADMINISTRATIVE LAW JUDGES

Ms. Roybal-Allard: The Social Security Administration's FY 2009 Budget does not propose significant increases in Full Time Employees for the agency. Instead, it proposes to increase FTEs by only 229 positions. Meanwhile, however, many current FTEs are retiring or leaving the SSA, which means that many offices are understaffed. The budget does, however, propose to increase by 175 the number of Administrative Law Judges.

Why has the SSA chosen to increase the number of ALJs without significantly increasing the numbers of support personnel for these judges? Won't this leave judges without the support they need to reduce the disability backlog?

Mr. Astrue: Thanks to additional funding provided by Congress in fiscal year (FY) 2008, our hearing offices will be able to replace all of their staff losses this year. In FY 2009, the President's Budget provides for an adequate number of support staff per judge to meet our performance commitments.

In FY 2009, in addition to adequate funding, we will depend on major automation initiatives to meet our performance commitments. We are developing a number of electronic initiatives that would reduce the lengthy preparation time needed to prepare a case for the Administrative Law Judge (ALJ) and ultimately decrease the number of support staff needed per judge. The electronic folder has already been implemented and has the potential to significantly decrease the time it takes hearing office staff to prepare and exhibit files, associate correspondence, prepare and send notices, and transfer workloads. Centralized printing and mailing will streamline the processing of the millions of documents sent annually by hearing offices. Finally, a new electronic file assembly tool called ePulling will support preparation of electronic cases for a hearing and dramatically reduce the time necessary for the file assembly portion of electronic folder preparation. At the hearing level, ALJs need the ability to sign decisions electronically. Currently, decisions are printed, signed and then scanned into the electronic folder. By implementing electronic signature capacity, the adjudicator will be able to complete the decision-making process electronically, thus sending the signed decision directly to the electronic folder. Although I recognize that automation will never completely replace people, it is important that we automate as much as possible to use our resources as efficiently and effectively as possible. The impact of our initiatives to increase ALJ productivity cannot be determined until enough time has elapsed to permit full evaluation.

We are conducting an analysis to determine the ideal ratio of support staff to ALJ. Since I began my tenure as Commissioner, I have increased the ratio of support staff to ALJ from 4.1 to 1 to 4.4 to 1. Further study is needed to determine if this ratio will be optimal in the future as we progress from paper to a fully electronic environment and implement automation initiatives described above. We anticipate the analysis can be completed by the end of FY 2009, but much depends on the successful design and implementation of major automation initiatives, and our ability to establish national task time standards. Should our analysis of the support staff ratio reveal that current levels have not benefited from the automation initiatives as expected, we ask that future budgets reflect the extra need and provide for appropriate funding.

Ms. Roybal-Allard: Your FY 2009 budget states that the SSA plans to automate many of its services, therefore reducing the need for FTEs. How will you account for the fact that it takes human capital to create hearing adjudication decisions and reduce the backlog?

Mr. Astrue: A number of electronic initiatives are being developed which would reduce the lengthy procedure to simply prepare cases for the Administrative Law Judges (ALJs). However, even with all of these improvements, adequate staff is still a critical component of the Hearings Backlog Reduction Plan. Our goal is to reach a level of 1,250 ALJs (and adequate support staff) in fiscal year (FY) 2009.

A large piece of our backlog initiative is focused on more fully automating processes. Although these initiatives will not eliminate the need for human capital, they should automate the more routine clerical functions, thus allowing us to utilize our staff

resources to perform those more difficult tasks which require human intervention and therefore cannot be automated. Many of these initiatives are identified in my response to the previous question. Until these automation initiatives are fully functional and our staff is trained in their implementation, we will continue to have a need for staffing at current levels.

Sufficient funding in FY 2009 and beyond is essential to ensuring that we can maintain an adequate number of ALJs as we continue our efforts to reduce the hearings backlog. The President's Budget commits to the correct balance of automation and people necessary to reduce the hearings backlog. As I responded to the previous question, although I recognize that automation will never completely replace people, it is important that we automate as much as possible to use our resources as efficiently and effectively as possible.

WEB SITE ACCESS FOR THE VISUALLY IMPAIRED

Ms. Roybal-Allard: There are 7 to 10 million blind and visually impaired people in the United States, and with the aging of the baby-boomer generation, that number is expected to increase by another 4 million by 2015. It is my understanding that these individuals rely on "screen readers" to navigate the internet, yet experts report that as many as 98 percent of all web sites are inaccessible to the disabled, including the SSA website.

Given that part of the Social Security Administration's mission is to provide assistance to disabled individuals, why would you make your website inaccessible to this population?

Mr. Astrue: The Social Security Administration (SSA) has a high rate of accessibility for the blind and visually impaired for all content published on the SSA website (www.socialsecurity.gov), including benefit applications. This is supported by documentation from the most recent Department of Justice (DOJ) survey (released in 2007) and an independent third-party study commissioned in 2005, which indicated that SSA's website was one of the most accessible websites to the blind and visually impaired in the Federal Government.

The DOJ's review of SSA's website found an "above-average level of success in implementing and enforcing web design policies that incorporates accessibility, and a highly above-average level of success in making web pages accessible." The independent third party study found that, "The SSA site is highly compliant with the Section 508 requirements, and presented a pleasant user experience for individual with disabilities utilizing the pages with leading assistive technologies...SSA's exceptional status in this regard is noteworthy. Further, all use cases and critical functionality within the site could be readily accessed and controlled using a variety of different assistive technologies."

The SSA website is evaluated for accessibility with industry-leading screen reader software, screen magnification software and automated testing tools. The SSA website is designed to achieve compliance with Section 508 standards, which establish Federal technical guidelines for ensuring access by the blind and visually impaired. SSA web pages are designed using templates that have been pre-tested for Section 508 compliance.

Specifically for the low-vision community, SSA also provides instructions on how to increase the font size of the website, and provides magnification software at no cost to the user. We evaluate SSA online systems with members of the general public, including persons with vision impairments. SSA is working to continue to include the visually impaired in its usability testing for both internal and external applications. SSA actively investigates the needs of the public with regard to Internet-based service support, including specialized needs of the elderly, and their interests and attitudes towards using Internet systems versus other means of doing business with SSA.

Even after achieving compliance, we still look for ways to further improve our accessibility offerings and make the website even easier to use for the visually impaired. These many activities ensure the Agency focuses on the needs of the blind and low vision community from concept all the way to implementation.

Ms. Roybal-Allard: Do you have any plans to rectify this?

Mr. Astrue: If there are any specific Section 508 or accessibility issues found by blind or low vision members of the public or through internal testing, all efforts are made to remediate and correct in a timely manner. Social Security Administration (SSA) Section 508 policy and procedures are in place to ensure that websites, electronic documents, and applications published on the SSA's public website are fully accessible to persons with disabilities.

Ms. Roybal-Allard: Since it is your stated plan to increase automated services within the SSA, how will you make your services more accessible to individuals with disabilities, who are more likely to need one-on-one personal assistance to navigate complicated bureaucracy?

Mr. Astrue: I understand your concern and that there are people who will need some assistance filling out forms. That is why I am committed to maintaining our community-based service structure, which includes 1,261 field offices across the country and personal service via our 800-number, 1-800-SSA-1213. We recognize that people will not always want to visit a field office. Many members of the baby boom generation, for example, will want and expect electronic service to be available. In fact, the first baby boomer to apply for retirement benefits applied on-line. By providing in-person, telephone and electronic service options, we can reach all Americans.

The development community at the Social Security Administration (SSA) is supported by dedicated resources with internal accessibility training and awareness campaigns, accessibility planning and design consulting services, and testing for Section 508 compliance using a structured testing methodology.

In fact, an office within SSA has the responsibility of ensuring that our software applications are efficient, easy to use, secure, and Section 508 compliant. SSA is committed to providing "access for all" by designing, developing, and implementing technology that is accessible to people with disabilities. SSA's Internet Usability staff tests our online systems with members of the general public, including persons with vision impairments. SSA is working to continue to include the visually impaired in its usability testing for both internal and external applications. Initiatives are underway to complete the analysis of the unique recruitment activities required to reach the visually

impaired. Efforts are also underway to analyze the feasibility of creating a special test environment that can support usability testing making it easier to recruit all types of test participants, including the visually impaired. These many activities ensure the Agency focuses on the needs of the blind and low vision community from concept all the way to publication.

FIELD OFFICE CONSOLIDATION

Mr. Udall: Commissioner Astrue, as you know I represent a district that is extremely rural. Many of my constituents rely on their local Social Security office for assistance and without it they would have to drive hundreds of miles to Albuquerque to receive the same assistance. There is significant concern, which I cannot underscore enough, that SSA is looking to close those offices that employ 15 or fewer people. I can tell you that this includes almost all of the offices in my rural district. Two weeks ago you sent me, and I presume the other members of this subcommittee, a letter stating that there was not a list of any such offices slated for closure but that each year "we do close or consolidate a small number of offices." Can you tell me the criteria by which you choose offices for closure or consolidation?

Mr. Astrue: The Social Security Administration (SSA) does not have a plan to close offices with 15 or fewer employees or any generalized plan to close offices. On the contrary, we fully understand that these offices are the means by which we serve a majority of the American public, and I am committed to maintaining our community-based service model. I am including at the end of this response the letter I sent you and many of your colleagues that refutes the allegation that SSA is planning a large scale closure of offices.

SSA does not make the decision lightly to alter the location of any Social Security office. As we strive to meet the needs of every community, we heavily weigh the results of a proposed change to any Social Security local office. Given budget realities and decreasing staffing, however, we must be conscious of the fact that Social Security services are dependent on resources and the Agency's capacity to improve productivity. One of the fastest growing parts of SSA's administrative budget is the cost of "bricks and mortar" infrastructure. SSA has over 1,400 field and hearings offices throughout the country. Increases in office space rent and other fixed costs (such as guards and employee pay and benefits) currently require a minimum annual increase of approximately \$400 million. By reducing costs where possible, SSA can redirect funds needed for core workload processing. Consolidation of field offices allows for improved workload processing.

At least once every five years, each Social Security office receives a comprehensive evaluation, or a "service delivery assessment." As a part of this process, SSA looks at the number of individuals coming into the office, office locations in the geographic area, and movement within the general population. Most of the time, we find that our local presence continues to meet the service needs of our beneficiaries. However, on occasion we find that resources would be better utilized and service to the public improved, by a consolidation of two offices within a close proximity.

What is SSA's Service Delivery Assessment (SDA) Process?

SSA's SDA process is comprehensive and long-standing, and balances service delivery with the cost of providing service. Service area reviews may be warranted when workloads increase or decrease, population increases or decreases or other demographic factors change. Other reasons for review include staffing changes or imbalances and lease or space considerations. These events may suggest the need for a review; however, all facilities are to be assessed at least once every 5 years to ensure

they are fulfilling the Agency's mission and effectively meeting the needs of the community.

Experience indicates that field office changes have to be examined on a case-by-case basis. There are unique factors that affect each decision, including the type and size of workloads, distance from other facilities, availability and use of public transportation in the community, quality of roads and the presence of geographic barriers (e.g., rivers). Each factor can play a role in these decisions. Other factors such as demographic changes, economic conditions and the proximity of private and public institutions also influence the decision.

SSA's regional commissioners are responsible for overseeing the SDA program in their regions. The identification and scheduling of the service areas to be reviewed, completion of the reviews, and actions taken as a result of the reviews fall under their authority. Progress reports are not required by headquarters; however, regional recordkeeping is required to assure full adherence to this process. On occasion, individual assessment information for a single office may be requested to respond to service inquiries at the national level.

Please note that SSA does not have a plan to close offices with 15 or fewer employees or any generalized plan to close offices. On the contrary, the Agency remains committed to providing tailored public service employing a network of accessible, community-based field offices. Periodically, SSA analyzes these offices through an SDA to ensure that service delivery is consistent with the needs of the area being served.

The SDA process consists of the following steps:

- 1) The regional office schedules field offices for review and collects demographic and workload data.
- 2) Accessibility, unique service area characteristics and special needs are documented by local management. Since convenience for service area residents is central to SSA's community-based service, the following must be considered and documented in the SDA narrative:
 - Average distance and travel time to the field office for beneficiaries from home;
 - Accessibility from major highways and roads;
 - Availability, convenience and cost of public and privately-sponsored transportation;
 - Availability, convenience and cost of parking for the public and employees; and
 - Accessibility for people with disabilities (transportation, parking, building accommodations, etc.).
- 3) Unique service area characteristics are considered and must be documented if they are relevant to the recommendation for change/no change. The following list is not all inclusive; it only highlights those characteristics that are common to many service areas:

- Safety/high risk location
 - Bilingual needs
 - Minority population needs
 - Location of trade or business centers
 - Proximity to social service/community agencies and organizations
 - Proximity to and collaborative work activity with other local, State and Federal government agencies
 - Level of advocacy group interest
 - Proximity to major institutions (e.g., educational, medical, cultural)
 - Availability of communications media outlets (target audiences, extent of coverage)
 - Proximity of large employers
- 4) Local management completes a careful review and analysis of the data and produces a narrative discussion and summary analysis of the service area needs and current service delivery. This results in a recommendation to maintain or to change existing service.
- 5) The completed SDA and any accompanying change proposals are sent to regional management for review. Any proposal that involves a change (such as a proposed consolidation) is then forwarded to headquarters personnel for review and approval.

How Does SSA Decide an Office Consolidation is Needed?

Many factors affect SSA's decision to consolidate existing field offices. The decision to consolidate is made only after an in-depth analysis of the SDA has been completed. SSA policy requires that a recommendation for consolidation must include an analysis of the following:

- The demographic and workload data for the most recent fiscal year;
- Existing and projected population of the new service area;
- Expected service delivery improvements as a result of consolidation;
- Planned presence in the old location; e.g., a reduced hours contact station to meet the needs of the public. A contact station is an SSA facility that is not permanently staffed. Instead SSA employees visit on a schedule to conduct SSA business. Contact Stations provide face-to-face service for communities or neighborhoods without easy access to full service field offices;
- Effect on the public as a result of consolidation;
- Discussions held with various community leaders, elected officials and local institutions;
- Availability and cost of space for housing the consolidated office;
- Cost to modify existing facilities for consolidation;
- Planned management of the service area by the newly consolidated office; and
- Disbursement of existing staff to other field offices.



The Honorable Tom Udall
House of Representatives
Washington, D.C. 20515

Dear Mr. Udall:

One of our union officials recently sent Members of Congress an inflammatory letter making the absolutely untrue claim that "hundreds of offices" were slated for closure. To make this letter even more reckless, it included a list of specific offices that were supposedly scheduled to close. That list is also a malicious fiction.

This propaganda campaign is a reprehensible attempt to mislead Congress for partisan purposes. For decades SSA has reviewed the status of a small number of offices as leases approach expiration and in each year, after Congressional and community consultation, we close or consolidate a small number of offices. We also try to open a few offices each year to respond to demographic shifts.

Although Congressional budget cuts have brought SSA to the brink of furloughs in recent years, we value our field operations, and we have had a net loss of just twenty field offices from the 1287 we had a decade ago. We anticipate no significant changes going forward unless Congress forces such changes with dramatic budget cuts.

You should also know that our procedures call for extensive Congressional district office and community consultation before we change the status of an office. Finally, while I do not feel a need to make a point-by-point rebuttal to all the misrepresentations in the letter, you should note that our FY 09 budget calls for a 6% increase in the SSA budget and that the supporting documentation provides detailed information about our plans for improving service to the public. I ask you to support that budget.

If you have any concerns about this subject, please feel free to contact me.

Sincerely,

Michael J. Astrue

STATUS OF FIELD OFFICES IN NEW MEXICO

Mr. Udall: Commissioner Astrue, as a follow-up, can you tell me the current status of each of New Mexico's Social Security offices? When are their leases up, how many employees does each office have, and are any of them at any part of the process for being considered for closure or consolidation by your office?

Mr. Astrue: There are no closures or consolidations pending for any field offices in New Mexico. We plan to open an office in Rio Rancho in 2009. The lease of the Carlsbad office (with 3 employees) expires in 2011 (with a scheduled relocation in 2008), the leases of offices in Farmington (26 employees) and Las Cruces (24 employees) expire in 2012, the lease of the Gallup office (13 employees) expires in 2013, the Clovis (11 employees) and Roswell (9 employees) office leases expire in 2014 (Roswell is currently expanding its space), the Albuquerque (68 employees) and Las Vegas (8 employees) leases expire in 2018, the Hobbs (8 employees) and Santa Fe (19 employees) leases expire in 2019, and the Albuquerque Teleservice Center (545 employees) lease expires in 2021.

ELECTRONIC SERVICES COMPLEMENT FIELD OFFICES

Mr. Udall: Commissioner Astrue, I applaud the efforts of yourself and others at SSA to strengthen your internet capabilities and offerings. However, I am concerned that there will come a point where these services are looked at not as a supplement to field offices and employees, but a replacement. I can tell you that many of the rural communities in my district often do not have access to high speed internet, or in the case of many of our tribal communities do not have any internet access. Additionally, I have spoken with many elderly constituents who are not computer literate and have significant trouble navigating the internet. Can you assure us that the SSA website will continue to be a supplement and not a replacement for field offices?

Mr. Astrue: I can assure you that our website and online applications will never be a replacement for our field offices. We recognize that some of our customers do not have access to a computer, are not computer literate, or may simply prefer to come into a field office. As such, our electronic services serve as a complement to our field offices and 800-number, rather than a replacement. Some of the new electronic services we will be offering are a much improved and easier to access claims application package that will help ensure that claimants file for all benefits to which they are entitled and a more user friendly disability application that will streamline the filing process and improve the quality of data we receive. We also will offer the capability for third parties, such as personnel offices, to help individuals file for retirement benefits.

We are committed to continuing our tradition of community-based service. However, we recognize that people will not always want to visit a field office. Many members of the baby boom generation, for example, will want and expect electronic service to be available. In fact, the first baby boomer to apply for retirement benefits applied on-line. By providing in-person, telephone and electronic service options, we can reach all Americans.

HEARINGS BACKLOG

Mr. Walsh: In 1996, Congress held a hearing which dealt with the Social Security disability claims backlog and it was determined that the Mobile, Alabama office had a backlog of more than 6,000. Today, that number has grown to almost 8,000 cases. Of the 12 Administrative Law Judge (ALJ) positions in the Mobile office, only nine are currently filled. Given that the backlog has grown and will surely continue to do so, how and when will the most recent ALJ hires effect the Mobile office's backlog? Even if the Mobile office was staffed with 12 ALJs, will that number be adequate in the future to keep up with the current caseload?

Mr. Astrue: The Mobile Hearing Office will receive four additional Administrative Law Judges (ALJs) in FY 2008 to increase its adjudicatory capacity and assist with reducing the backlog. These additions will fill every available ALJ office in Mobile. As a result of the new ALJ hires, we estimate that the pending cases per ALJ will be reduced to 593 and receipts will drop to 499 cases per ALJ. We believe that this is an adequate number of ALJs to address Mobile's current and anticipated workload.

ADMINISTRATIVE LAW JUDGE APPLICATION PROCESS

Mr. Walsh: This past fall, the Social Security Administration solicited applications for Administrative Law Judge (ALJ) positions. Though the SSA acknowledged the shortage of ALJs and the consequent need to hire many new judges, the application process was closed after just a few hours. Why was the window for applications so narrow? If it was closed because of the volume of applications, what reason does the Social Security Administration have to believe the applicants who submitted an application before the process closed were any more qualified than the applicants who were shut out? When do you anticipate the current 600 applicants will be exhausted and the window for new applicants open again?

Mr. Astrue: The Office of Personnel Management (OPM) opened the new Administrative Law Judge (ALJ) Examination on May 4, 2007 with a closing date of May 18, 2007 or until the day on which the 1,250th completed application had been submitted, whichever would have come first. OPM closed the examination on May 11, 2007, because 1,250 applications had been submitted by that day. OPM had total authority over this decision and how the application process would be handled. We believe they handled the process as they did because the examination had not been open for many years and a large number of applications was expected. Also, they automated the entire application process and, with a smaller number of applications, could resolve any problems in the application process.

We believe there were excellent candidates who did not meet the deadline. However, as a result of the Social Security Administration's request to OPM on November 19, 2007 to fill 150 ALJ vacancies in 71 locations, we received 450 well-qualified candidates for our positions. We have just completed the selection and notification process. As a result, 136 new ALJs will be reporting in April, May and June of this year.

We have just forwarded a request to OPM to reopen the ALJ Examination so that there will continue to be sufficient candidates to meet our hiring needs for the future. We hope they will respond favorably to this request.

ADMINISTRATIVE LAW JUDGE ACCOUNTABILITY

Mr. Walsh: The lack of accountability and inconsistent performance across the ALJ corps has been noted as a reason behind the backlog. What processes are currently in place to enforce accountability among the ALJs? What performance standards could be implemented that would encourage, or monitor, appropriate professional and personal conduct as well as judicious performance amongst the ALJ corps?

Mr. Astrue: Performance standards for Administrative Law Judges (ALJs) would be helpful to improve service to the public. However, Office of Personnel Management (OPM) regulations govern ALJ appointment, performance accountability and removal, and those regulations preclude agencies from rating ALJ performance. As a result, current practices for addressing ALJ productivity issues, such as failure to hear and decide cases in a timely manner, include the following: meeting between the Hearing Office Chief ALJ and the ALJ in question to identify the source of the problem, directing the ALJ to hear and decide cases that are within the ALJ's control in a reasonable time, mentoring as needed, and written counseling. Disciplinary action may be proposed if the above approach is unsuccessful. Disciplinary action is governed by OPM regulations, and Agency action, above a Reprimand, must be approved by the Merit Systems Protection Board (MSPB) before it can be effectuated.

Despite the many obstacles, we still pursue allegations of ALJ misconduct. Because OPM has been charged with responsibility for administering the ALJ program, OPM should be included in any legislative changes.

IDEAL RATIO OF SUPPORT STAFF TO ADMINISTRATIVE LAW JUDGES

Mr. Walsh: In 2005, the SSA Inspector General issued an audit report entitled "Effect on Staffing on Hearing Office Performance", which found a direct correlation between the timeliness and numbers of disposition rates and staffing levels. It advised that SSA Management "establish and implement an ideal staffing level ratio for hearing offices nationwide". Did SSA ever devise an ideal staffing ratio? Has the Inspector General, or other independent auditor, analyzed caseload performance metrics by region? Is there one specific region that could/would serve as a model for other regions?

Mr. Astrue: Agency practice to date has been to give hearing offices wide latitude in staffing and organizational decisions. As a result, staffing support levels vary by office. As we move to unify electronic systems and business processes at our hearings offices nationwide, we will consider alternate ways of determining appropriate support needs of the offices.

"FAVORABLE EVIDENCE" REGULATION

Mr. Walsh: Regarding the development of a claimant's record, there apparently exists a regulation commonly referred to as "favorable evidence", which allows placement into the claimant's record a disability diagnosis provided from one doctor despite the fact that any number of other doctors would disagree that a disability actually exists. To which regulation does this refer to? How often is this "favorable evidence" regulation exploited to pay out disability claims?

Mr. Astrue: While we do not have a regulation called "favorable evidence," we believe you are referring to the "Treating Physician Rule," which confers special weight on the opinions of a claimant's treating physician because of the ongoing treatment relationship. The rule restricts the Agency's discretion in evaluating these opinions if the treating physician's medical opinion is well-supported by the objective evidence and is not inconsistent with other evidence in the file. Otherwise, it requires our adjudicators to weigh the opinion in the balance with the other evidence, considering such things as how well the physician knows the claimant and whether the physician is a specialist for the allegedly disabling condition. In some cases, this rule may be misapplied, resulting in some inappropriate awards of benefits, but we do not routinely collect data on the impact of this rule on our overall allowance rates.

This rule does not apply to opinions on some issues, such as whether the claimant is "disabled." These are not medical opinions, but are, instead, opinions on issues reserved to SSA because they are administrative findings that are dispositive of a case; i.e., they would direct the determination or decision of disability. We do not give any special weight to such opinions. Determining disability is not simply a medical determination. It also requires an evaluation of other factors, such as a person's vocational or occupational skills and whether jobs exist in the national economy that such a person could perform.

ELIMINATING FRAUDULENT "GAMING" OF THE DISABILITY SYSTEM

Mr. Walsh: Given the existence of websites in the public domain that provide tips on "How To Win" disability benefits, what can be done within the Continuing Disability Review program to further eliminate any fraudulent "gaming" of the disability system.

Mr. Astrue: We regularly perform a continuing disability review (CDR) to determine if individuals receiving disability or blindness benefits continue to be disabled. The frequency of the review is based on the individual's impairment(s). Regardless of the scheduled time for the CDR, if a question of continuing disability is raised, a CDR should be performed immediately.

We have established a Cooperative Disability Investigations (CDI) Program in our Office of the Inspector General (OIG). This program is a joint effort among Federal and State agencies to effectively pool resources for the purpose of preventing fraud in the Social Security Administration's disability programs and related Federal and State programs. Disability cases may be referred for investigation if fraud is suspected during the processing of a CDR.

The CDI Program is just one way OIG and SSA work together to prevent and detect fraud, waste, abuse, and mismanagement in SSA's programs and operations.

[The following questions were submitted to be answered for the record:]

REGIONAL DISPARITIES AMONG ADMINISTRATIVE LAW JUDGE CASELOADS

Mr. Obey: In your audits of the performance of ALJs, you uncovered some regional disparities in ALJ caseloads. What are the reasons for these disparities? What is the Agency doing about them?

Mr. O'Carroll: Our audit identified three regions where ALJs were most likely to process a higher number of cases. However, the causes of these disparities were not discovered in the course of our review. We recommended that SSA look at the possible causes of both regional and hearing office disparities, and the Agency agreed to do so.

We are currently performing a Congressional Response review on ALJ and Hearing Office performance. This review will provide possible reasons why certain regions and hearing offices perform at varying levels.

SUPPORT STAFF FOR ADMINISTRATIVE LAW JUDGES

Mr. Obey: Would you care to comment on Judge Bernoski's testimony concerning the need for sufficient staff support—both clerical support and decision writers—and how this relates to any expectations about ALJ disposition rates? Have you looked at this issue, or plan to look at the issue in the continuing work you are doing on the issue of the disability backlog? Have you looked at the issue of having the ALJs supervise their own staff?

Mr. O'Carroll: We conducted an audit entitled *The Effects of Staffing on Hearing Office Performance*. In that audit, we found that during the 5 previous years, the number of dispositions per day per ALJ had improved (from 2.03 to 2.40 cases), yet timeliness had declined (from 316 to 391 days). While some factors contributing to this apparent contradiction were beyond SSA's control (such as an ALJ hiring freeze and an increase in claims) the decline in timeliness could result to some extent from SSA's allocation of staff. We found that while the national average staffing ratio was 4.7 support staff for each ALJ, offices ranged from a national low of 3 support staff per ALJ to a high of 18.5 support staff per ALJ. Of the 76 hearing offices with a ratio below the national average of 4.7 to 1, 63 percent had disposition rates below the national average. We recommended that SSA establish an ideal staffing ratio for hearing offices.

In addition, we have audits in our workplan to look at staffing issues, including whether ODAR has the right allocation of support positions within the hearing office, the right duties assigned to those positions, and sufficient oversight to ensure adequate performance. We are also considering an audit on the performance of decision-writers, who play a critical role in hearing office workload.

We have not performed any work to determine if supervision of hearing office staff by individual ALJs would improve performance, but will explore the possibility of such work in future audits.

DISABILITY WATERFALL

Mr. Obey: Can you provide any information that would reconcile the 97 percent accuracy rate for decisions made by the Disability Determination Services on the State level with the fact that more than 60 percent of the cases taken to appeal are ultimately approved?

Mr. O'Carroll: There are a number of factors involved in what at first appears to be a contradiction. First, a different standard of proof is applied in the hearing process than is applied at the initial application stage. While we have not done work with respect to the effect this may have, we believe it may be a factor in the apparent disparity. Second, many cases allowed on appeal are due to medical conditions that have worsened by the time an appeal is heard. Third, applicants at the appellate level are more frequently represented by counsel, who are better able to present the applicant's case in a light which conforms more closely to the requirements of the disability program. Fourth, at the appellate level, additional evidence is often obtained and included in the record. In short, the cases that are heard by ALJs are generally the "close calls," are better and more thoroughly presented, and may involve deteriorating medical conditions. We are not aware of any evidence that would demonstrate that there is a flaw in the disability determination and appeals process in this regard.

ATTRITION RATES IN DISABILITY DETERMINATION OFFICES

Mr. Obey: What can you tell us about the high attrition rate in DDS offices, the causes of that attrition, and the effect on performance?

Mr. O'Carroll: In an audit entitled *Disability Determination Services' Claims Processing Performance*, we discovered that poor-performing offices were consistently those that experienced the most attrition, the fewest disability examiners in relation to total staff, and those that purchased consultative examinations with the most frequency, rather than waiting for medical documentation from the treating physician that is often delayed.

With respect to attrition specifically, we found that during FYs 2000 through 2002, at least 458 examiners left the employment of the 10 DDSs in our review.

Approximately 50 percent (228 of the 458) of the examiners left the employment of the 10 DDSs in our review because of reasons related to job quality, such as other employment, low salary, job stress, and low morale. The remaining examiners left because of reasons such as retirement or relocation.

PROCESSING TIME IMPROVEMENTS

Mr. Obey: Has e-Dib improved DDS processing times? What other technology improvements could be utilized by both DDS and ODAR to improve processing time and to monitor workloads?

Mr. O'Carroll: We have found that, overall, e-Dib has had only a marginal effect on processing time, and are looking at ways to examine this phenomenon in order to

supply SSA with recommendations on how e-Dib might be better used to improve performance.

With regard to other technology improvements, we found in a 2006 audit entitled *Case Processing and Management System and Workload Management* that the Office of Disability Adjudication and Review's (ODAR) Case Processing Management System (CPMS) was accurate, but that ODAR management did not always use CPMS reports in their caseload management, particularly with respect to stagnant cases. We made recommendations to improve the use of CPMS and SSA agreed with our recommendations.

A year later, we conducted an audit entitled *Management's Use of Workload Status Reports at Hearing Offices*, which was designed to assess the "No Status Change" indicator which is attached to stagnant cases. That indicator can be attached to a case by CPMS at 12 different stages of case processing, from "Master Docket," where the case is first entered into CPMS, to "Mail," where the final decision is sent to the claimant. The number of days that must elapse before the "No Status Change" indicator is attached (and the case appears in the "No Status Change" management report), varies for each of the 12 stages.

We examined the workload status reports to determine where bottlenecks occurred that would significantly delay case adjudications and identified the three most significant obstacles to timeliness. We also found that more than 50% of cases were not being tracked at all, including hundreds of thousands of unworked cases. We made several recommendations to SSA to improve its processes to take full advantage of CPMS, and SSA agreed with our recommendations.

QUICK DISABILITY DETERMINATION PROCESS

Mr. Obey: Your testimony discusses your review of SSA's QDD process, and mentions the recommendations from that review. What has the Agency response been to those recommendations?

Mr. O'Carroll: With respect to our first recommendation, that SSA ensure that non-medical aspects of Quick Disability Determinations (QDD) claims processing are expedited, SSA agreed with the recommendation. SSA stated that training of staff was key to this issue, and that in addition to issuing formal procedures, it had developed a Workload Action Control system to make it easier to identify and take timely action on these cases. It appears to be working well to solve the issue raised.

SSA disagreed, however, with our second recommendation, that it consider refining the QDD selection process in the future, prior to rolling it out to another region, to focus on Supplemental Security Income claims and Disability claims at the end of, or beyond, the statutorily required waiting period. SSA stated that it had seriously considered this recommendation, and decided not to implement it at this time for several reasons:

First, SSA stated that due to the computer systems through which the predictive model is run, it cannot tell whether a case is Title II or Title XVI or if a waiting period applies. To change this would require costly systems reprogramming.

SSA also stated that the onset date, which determines when the 5-month waiting period begins, is an allegation at the beginning of the process. It isn't until the actual disability determination is made that the exact onset date is determined. Until then, SSA cannot know where the claimant is in terms of satisfying the 5-month waiting period.

Finally, SSA stated that there are public policy benefits to making a determination as early in the process as possible, regardless of cash benefit status. Examples SSA cited include: resolving claimant anxiety; having an SSA determination for purposes of other public or private benefits; and, allowing individuals to notify private entities, such as landlords, loan companies, and health insurance providers, that they will have an income in the near future, thus possibly avoiding eviction or postponing collection activities.

The OIG understands that SSA has limited resources and, according to the Agency, it would be costly to reprogram the QDD predictive model at this time. However, we still believe SSA should consider making the changes necessary to implement our recommendation when future programming changes are made. We believe individuals who will immediately benefit from expediting processing (those with SSI claims and DI claims at the end of or beyond the statutorily required waiting period) should receive priority over individuals who might benefit from receiving an allowance determination prior to their eligibility for benefits.

IMPROVING E-DIB

Mr. Udall: Mr. O'Carroll, as you mention in your testimony, e-Dib was meant to improve staff performance and productivity by allowing for the electronic transfer of claims materials, eliminating the delays often caused by having to ship and send such materials. Yet, you found that it has only "marginally improved processing times or reduced backlog." Can you expand a little further on why this is and tell us what you think can be done to improve this process?

Mr. O'Carroll: As I mentioned in my testimony, we have been looking at ways we might be able to determine why e-Dib has not been more effective in this regard. Initially, we intend to conduct two audits:

The first will determine the status and impact of workaround issues identified during and after SSA's Independence Day Assessment (IDA) process which certified Disability Determination Services (DDS) to process disability claims using eDIB. This audit is based upon a previous review, entitled *The Social Security Administration's Independence Day Assessment*, in which we identified issues that impacted the efficiency of the e-Dib electronic folder (EF), referred to as workaround issues. Workaround issues occur when a problem in the EF cannot be immediately resolved. In this process, an alternate procedure is temporarily established to allow the electronic claims process to continue. Workaround solutions are cumbersome and adversely affect the efficiency of eDib because they require performance of additional steps—often outside the EF. We plan to complete this review in FY 2009.

The second audit will examine:

- the efficiencies eDIB has created in the disability process as they relate to productivity, reduced costs and improved processing times;
- barriers that are preventing SSA from achieving full efficiencies from eDIB, and
- SSA's plans for using the eDIB platform to further improve the timeliness of the disability process. We plan to begin this review in FY 2009.

**House Appropriations
Labor, Health and Human Services, Education
and Related Agencies Subcommittee Hearing**

**Reducing the Disability Backlog at the
Social Security Administration and FY 2009 Budget Overview**

**Questions for the Record for Richard Warsinskey
Past President**

National Council of Social Security Management Associations (NCSSMA)

Question Number 1: Mr. Warsinskey, as this Committee was preparing the FY 2008 appropriation for the Social Security Administration, we heard from many Members of Congress about field office closings that would have a negative impact on the SSA beneficiaries and claimants living in the Congressional districts where offices were closing. What is SSA doing to ensure that beneficiaries and claimants are getting the services they need from field offices considering the increased workloads at the agency and the retirement of a significant portion of SSA's own workforce?

Answer: SSA is making substantive efforts to help mitigate the impact of reduced resources for field offices. The following is a list of several actions the agency has taken:

1. SSA has reduced the number of Medical Continuing Disability Reviews (CDRs) and SSI redeterminations that field offices are required to complete. Although this costs taxpayers a substantial amount of money in the long term, it does give SSA field office staff more time to work on other cases and provide better services.
2. SSA has streamlined some of the agency's filing requirements. For example, signatures are no longer required for claims and many other actions. The claimant verbally attests to their signature. This reduces the volume of paper that field offices handle and the time it requires to prepare cases to be mailed and received back in the office. Birth certificates are no longer required in most retirement cases which also reduces the time field offices spend on a claim.
3. SSA is purchasing new telephone equipment for field offices. This equipment which will be installed over the next four years will give offices much better abilities to manage the incoming calls and provide for better distribution of the calls in the offices. This will not eliminate the high busy rates but it is anticipated that it will mitigate the busy rates.
4. SSA is encouraging the use of internet communications with the agency including facilitating claims and disability forms being completed on the internet by the public. If this information is properly filled out, it should reduce the amount of time the field offices have to spend on claims and other actions as the keying action is more clerical in nature. A new internet product that is due out this fall should require less manual action to correct the internet claims.
5. SSA continues to offer the early out retirement program to bring in new employees who will provide the backbone of the SSA workforce in the future.

Question Number 2: Mr. Warsinsky, in your testimony you suggest that an additional \$200-\$250 million is necessary in FY 2009 over and above the President's request in order for SSA to meet all of its service delivery responsibilities and not only the hearing backlogs. Your testimony indicates that the agency's other workloads will be almost on auto-pilot until the hearing backlogs are reduced, which SSA estimates will not be until 2013. You present a lot of management challenges in your testimony. Specifically, what could be accomplished with the increase you are suggesting over the President's level?

Answer: We believe the following could be accomplished if SSA were to receive \$200-\$250 million above the President's proposed budget for Fiscal Year 2009:

1. SSA projects that by Fiscal Year 2009 there will be an 8,100 work year backlog in SSA if the President's budget request is approved. If provided, additional funding would help SSA begin to address this backlog. It is important to note that the backlog would not be eliminated. SSA has estimated it would take an additional \$729 million above the President's budget request to eliminate the entire 8,100 work year backlog. Examples of the types of workloads included in this backlog are: updating the amounts that beneficiaries are due, collecting additional overpayments, assisting in child support orders and Medicare enrollment actions.
2. In addition to the work year backlog mentioned above, the most visible backlogs are the disability hearing requests. Under the President's FY 2009 budget request, SSA is still expected to have 683,000 hearings pending with average processing times in excess of 500 days. This backlog could be decreased and the processing times reduced if additional funding were provided.
3. SSA field offices would be able to provide better field office telephone service. Currently the busy rates for business related telephone calls to field offices is over 50% compared to less than 10% for SSA's 800 Number service.
4. SSA would be able to improve the quality of their work. There is little time for SSA staff to do substantive reviews of their cases because of the number of cases that need to be processed.
5. SSA would be able to process more Medical CDRs and SSI redeterminations. Under the President's budget request for FY 2009, SSA will clear about 471,000 CDRs and 700,000 fewer SSI redeterminations than earlier this decade.
6. SSA is seeing a record number of visitors to field offices. The number of visitors is expected to continue to increase as over a million plus additional baby boomers start receiving benefits starting this year. Waiting times for visitors would be reduced with additional funding.



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

April 8, 2008

The Honorable David R. Obey
Chairman
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Obey:

Thank you for your Questions for the Record in follow-up to the Subcommittee's February 28, 2008 hearing on Reducing the Disability Backlog at the Social Security Administration and FY 2009 Budget Overview. This letter is in response to those questions, which I have repeated below. If you or your staff would like further information or discussion on anything included below, I would, of course, be happy to respond, as would my co-chairs from the Consortium for Citizens with Disabilities (CCD) Social Security Task Force. Please let us know if we can be of further assistance.

1. Ms. Ford, I am interested in getting your opinion on SSA's proposed rule on Amendments to the Administrative Law Judge, Appeals Council, and Decision Review Board Appeals Level. Does your organization believe that these changes benefit the claimant?

We had very serious concerns about the proposed rule and submitted extensive comments on behalf of over 30 national organizations. Our overall reaction can best be summed up in the following four paragraphs taken from the introduction of the comments submitted by CCD.

We agree with the Commissioner that reducing the backlog and processing time must be a high priority and we urge commitment of resources and personnel to reduce delays and to make the process work better for the public. We strongly support changes to make the process more efficient so long as those changes do not affect the fairness of the procedures used to determine a claimant's entitlement to benefits. The notice of proposed rulemaking provides some positive changes. However, our overarching concern is that many aspects of the proposed process elevate speed of adjudication above accuracy of decision-making. Based on our perspective as organizations representing people with disabilities and their families and as advocates for claimants with disabilities, this is problematic and not appropriate for a nonadversarial process.

On balance, we urge the Commissioner not to implement this NPRM unless significant changes are made to protect the rights and interests of people with disabilities. Our measure is whether the process will be fair. While there are some positive proposed changes, e.g., a 75-day hearing notice (the current rule provides only a 20-day notice) and retaining a claimant's right to administrative review of an unfavorable ALJ decision, we believe that these proposals, individually identified here but also as a package, if not improved, will result in more decisions that are not based on full and complete records and are not fair.

We are very concerned that claimants will be denied not because they are not disabled, but because they have not had an opportunity to present their case. It is appropriate to deny benefits to an individual who is found not eligible, if that individual has received full and fair due process. It is not appropriate to deny benefits to an eligible individual simply because he or she has been caught in a procedural tangle. Especially vulnerable will be unrepresented claimants. However, we are concerned that even those who secure able representation at some point in the process will fall into the traps that would be set by the proposed procedural barriers in the NPRM.

While the current system is far from perfect, it does provide a great deal more flexibility to address and resolve problems in a claim. While this may lead to additional processing time for an individual case, it also means that the final decision will be more accurate, which should be the priority in a nonadversarial, truth-seeking process. We believe SSA can (and already is beginning to) speed up the process without sacrificing this basic concept of fairness.¹

On January 29, 2008, after the close of the public comment period, Commissioner Astrue informed Representative McNulty, Chairman of the Social Security Subcommittee of the Committee on Ways and Means, that in light of the concerns expressed by the public and Members of Congress, he was suspending the rulemaking process for several of the provisions that have become controversial.

Following that announcement, Commissioner Astrue met with members of the National Organization of Social Security Claimants' Representatives (NOSSCR) and CCD to discuss those areas of the proposed rule considered controversial. The CCD representatives felt the meeting was productive and believe that Commissioner Astrue and his staff are working in good faith to address the serious concerns raised by advocates. We look forward to another meeting or follow-up to those issues which SSA officials agreed to reconsider.

2. Ms. Ford, I think it bears repeating, the statement from your testimony that "Often, claimants are denied not because the evidence establishes that the person is not disabled, but because the limited evidence gathered cannot establish that the person is disabled."

¹ See: http://www.c-c-d.org/task_forces/social_sec/CCD_NPRM_comments_FINAL_12-27-07.pdf for the complete set of CCD comments.

What is SSA doing to improve efforts at the initial disability claims process at the field office level and at the State DDS level? What additional steps do you believe they need to take? Do changes require new regulation or can SSA make adjustments administratively?

SSA efforts to improve the initial claims process. Regarding improvements at the initial claims process level, we are most familiar with technological improvements including the electronic disability claims folder; “eDIB”; online applications; and electronic submission of evidence, known as “Electronic Records Express” or “ERE.” The Commissioner is strongly committed to improving and expanding technology initiatives, which we generally support so long as they do not infringe on claimants’ rights.

Many of these improvements will not only reduce delays, but also provide better service to the public, and do not require fundamental changes to the process. The initiative to process disability claims electronically has the prospect of significantly reducing delays by eliminating lost files, reducing the time that files spend in transit, and preventing misfiled evidence.

Additional steps that SSA can take to improve the initial disability claims process. We have a number of suggestions and recommendations to improve the initial disability claims process, which are not controversial and can be accomplished through administrative policy changes.

- **Improve development of evidence earlier in the process.** We strongly support full development of the record at the earliest point possible. This benefits the claimant and avoids unnecessary appeals, which contribute to the backlog. As detailed in our testimony before the Subcommittee, there are a number of ways that SSA and the state agencies could improve the process, none of which requires regulatory changes:

- Provide more assistance to claimants including: better explanation of the evidence that is necessary and relevant to the claim; and assistance with completing application paperwork so that all impairments and sources of information, including non-physician treating sources, are identified.
- Provide better explanations to medical providers regarding the disability standard and ask for evidence that is relevant and addresses the disability criteria.
- Require DDSs to collect relevant information from all treating sources, including non-physician treating sources (discussed in response to question 3, below).

- **Provide more training and guidance to adjudicators.** This training and guidance should focus on policies that are frequently misapplied, e.g., standards for weighing medical evidence, the role of non-physician evidence, evaluation of subjective symptoms, etc.

- **Expand use of existing methods of expediting disability determinations.** SSA already has in place a number of under-utilized procedures including “Quick Disability

Determinations,” Presumptive Disability” in SSI cases, and terminal illness (“TERI”) cases.

3. We have heard some discussion today about the benefits of a properly developed file both in terms of the evidence upon which an initial determination can be made, as well as the ability to adjudicate the case upon appeal. It is not hard to understand how different evidentiary records at different levels can produce different results. I am interested in how SSA might improve this process, including the quality of information that claimants receive as they complete their initial applications, the medical evidence that the DDS obtains from medical providers and through consultative exams, and the level of assistance available to claimants in the process.

- **Can more be done to help claimants, including the earlier use of advocates that are more common at the hearings level?**

As described below in the response to question 4, representatives play an important role in obtaining medical and other information to support their clients’ disability claims. Given the importance of representation, the Social Security Act requires SSA to provide information on options for seeking legal representation, whenever the agency denies a claimant’s application for benefits. 42 U.S.C. § 406(c); 42 U.S.C. § 1383(d)(2)(D).

Most legal representation occurs at the hearing level. A major reason is that it is only at that level, after the request for hearing is filed, that claimants are given concrete information regarding legal resources to contact. The hearing office sends the claimant an acknowledgment that the request for hearing was received and includes the names of organizations, both national and local, that can provide representation or a referral service. The list also includes phone numbers.

Even though many claimants’ representatives will represent claimants prior to the hearing level, the rate of representation is extremely low when compared to the hearing level. One reason is that claimants are given very minimal information, that is neither specific nor targeted, about how to obtain representation. Another reason is that many advocates report that claimants are in fact discouraged from obtaining representation at the reconsideration level by SSA claims representatives or telephone representatives.

The fact that claimants are discouraged from obtaining representation early in the process has been corroborated by the experience with the “Disability Service Improvement” (DSI) process in SSA Region I states. Since the inception of DSI in August 1, 2006, we were concerned about the representation rate of claimants at the Federal Reviewing Official (FedRO) level.² After the final regulations were published, SSA officials told us that they hoped more claimants would be represented at the FedRO level, which would help to develop the record and identify issues. Unfortunately, neither the statistics nor the experience of representatives supports the agency’s initial intent.

² Under DSI, the “FedRO” level was the first level of appeal, following an initial claim denial, and replaced reconsideration. See 20 C.F.R. § 405.201, *et seq.* As of March 23, 2008, new appeals to the FedRO level have been suspended. See 73 Fed. Reg. 2411 (Jan. 15, 2008), and 73 Fed. Reg. 10381 (Feb. 27, 2008).

According to statistics received in response to a FOIA request in 2007, the representation rate at the FedRO level was quite low - only about 24% of claimants. It was significant that the initial denial notice, as we described above, did not encourage claimants to obtain representation at the FedRO level and did not provide information to help them find representation resources.

The National Organization of Claimants' Representatives (NOSSCR), a member of the CCD Social Security Task Force, conducted a survey in mid-2007 of its members in SSA Region I states and asked whether they had been contacted by claimants at the ALJ level who had not been previously represented. The survey asked for the reasons why the claimants had not obtained representation at the FedRO level. Responses indicated that claimants were not aware that they needed or could obtain representation before the hearing stage. One representative responded that clients said that "[t]hey were told that they didn't need representation at either the initial or FedRO level. They got this information from the DO [district office] when they went in to file."

Another less legal role for claimant assistance earlier in the process is expanding the use of third parties to help individuals file applications. Many claimants, especially those with mental impairments, are affiliated with non-profit agencies. These agencies are in a unique position to help these individuals navigate the complicated application process and to ensure that accurate and complete information is provided at the very beginning of the process. They can assist the individual to obtain important medical and functional evidence and, if necessary, they may be in a position to provide the evidence necessary to support the claim.

Over the years, SSA has mentioned plans to expand the use of third parties and we urge the agency to make a concerted effort in this direction, especially with the expected improvement of its online disability application process. However, if SSA moves in this direction, it will need to have mechanisms in place to ensure that the organizations are acting in the best interest of the claimants.

- **Would the improvement and standardization of DDS forms so that the medical information requested is better tailored to the disability standard result in better development of the record at the front end of the claims process?**

We strongly believe that the DDS forms could be improved so that more complete and relevant information is obtained at the beginning of the process. Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. DDSs should update and improve their forms to specifically request necessary information, including collection of functional capacity information, which is generally obtained at the ALJ hearing level but less so at the initial levels.

In addition, SSA has created some national forms to collect evidence, but they vary in quality. The situation is further complicated because some DDSs use their own forms, which also vary in quality. SSA should review its own national forms and DDS forms

that are used to collect evidence, and set standards for state-specific forms to ensure higher quality.

- **Are the current procedures – and reimbursement rates – for consultative examinations sufficient to ensure their quality and appropriateness? Are some DDS's purchasing these exams rather than waiting for medical documentation from treating physicians – and why?**

It is critical for SSA and the DDSs to increase their reimbursement rates for all medical requests, both for records and for examinations. This will undoubtedly improve provider response rates. It also will help to improve the medical expertise available to adjudicators for consultative examinations and for medical experts.

The current low reimbursement rate is not sufficient to ensure the quality of consultative examinations (CEs) and undoubtedly is a factor regarding which doctors and psychologists are willing to conduct CEs for SSA. But this does not explain why claimants are referred to the wrong physician, given the disabling impairments. We hear far too many stories about inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's. This is wasted money for SSA and unhelpful to individuals, especially those with low incomes who do not have complete medical records documenting their conditions and who need a high quality CE report to help establish their eligibility.

It is important to note that the regulations allow SSA to pay treating physicians to provide CEs,³ but they are rarely used in that capacity. It is likely that the low reimbursement rate contributes to non-use of treating physicians for CEs. SSA should explore ways to expand use of treating physicians to provide this information.

Also, to ensure that its funds are being used as effectively and appropriately as possible, SSA should provide more oversight of the CE process, which is conducted by the state agencies.

It appears that some DDSs refer cases for CEs rather than wait for medical documentation from the claimant's treating sources, both physicians and non-physician (if requested). A significant factor is likely the fact that DDSs operate under processing time standards against which SSA measures their performance.⁴ Claimants' representatives frequently report on the problems with obtaining medical evidence – requests are often given low priority given the busy nature of many medical offices; reimbursement rates are inadequate; and many offices lack medical records staff. The DDSs face these same challenges and when coupled with the regulatory time constraints, we believe that the DDSs are under pressure to cut short efforts to obtain medical information from treating sources.

4. Can you describe the role of claimants' representatives in the disability claims process? How do claimants benefit from representation?

³ 20 C.F.R. §§ 404.1519h and 416.919h.

⁴ See 20 C.F.R. §§ 404.1642 and 416.1042.

The Social Security Administration's disability determination system is a complex, multi-level process. Appealing the denial of an application for disability benefits can be a daunting task for anyone without the necessary legal experience, but for individuals who are in poor health or disabled, the procedural hurdles that must be cleared in order to obtain disability benefits can seem insurmountable. As a result, many individuals applying for Title II or SSI disability benefits choose to obtain a representative to help with the appeal.

It is not surprising that individuals seek legal representation, given the individual challenges in each case and the undeniable importance of the outcome. Exactly why a claim has been denied is frequently a mystery to the claimant who receives an initial denial notice. Claimants often have been out of work for many months and have no income other than the financial support they receive from their friends, family, or non-profit organizations. Most have no health insurance and cannot pay for the medical treatments necessitated by their disability. They also understand that their family's welfare may be dependent on receiving disability benefits and the accompanying Medicare or Medicaid health insurance coverage.

The ability to have an experienced professional provide legal assistance is certainly valuable for claimants. SSA's statistics for FY 2006 indicate that the favorable decision rate for claimants represented by an attorney or nonattorney was 66.9%, compared to 52.1% for unrepresented claimants. It also is important to note that since 2005 when direct fee withholding began in SSI cases for attorneys and eligible nonattorneys, the representation and allowance rate for SSI claimants has increased in every year. Given the importance of representation, the Social Security Act requires SSA to provide information on options for seeking legal representation, whenever the agency denies a claimant's application for benefits. 42 U.S.C. § 406(c); 42 U.S.C. § 1383(d)(2)(D).

We believe the main reason for the higher allowance rate of represented claimants is due to the assistance of a knowledgeable representative who is familiar with the sequential evaluation process set forth in the regulations and Social Security Rulings. The representative marshals evidence from doctors and hospitals, other treating professionals (e.g., therapists, social workers, nurse practitioners), school systems, vocational testing centers, previous employers, and others who can shed light on the claimant's entitlement to disability benefits.

These trained and experienced representatives can also thoroughly examine vocational and medical witnesses during the hearing before the Administrative Law Judge (ALJ). These are daunting tasks for *pro se* claimants, especially when we consider that they are in poor health and many often have only a limited education.

Experienced representatives also are a valuable resource for SSA by helping to streamline the disability determination process. Attorneys and other representatives routinely explain the disability determination process and procedures to their clients with more specificity than SSA. In addition, they ensure a more efficient system by developing an accurate and complete medical and vocational record and presenting the supporting documentation and statements that the adjudicators require for a full and fair evaluation of the claim. Often, the evidence obtained by representatives and the legal briefs they prepare on behalf of

their clients contain the requisite evidence to support a finding of disability by an ALJ without the necessity of a hearing, thereby saving time and expense for both the Social Security Administration and the claimant.

5. What is the position of your organization on moving toward a formal adversarial hearing, rather than the inquisitorial format of current SSA hearings? What would be the impact on claimants of an approach that established “agency representation” in the hearing? Would there be any impact on the non-adversarial process?

We do not support proposals to have SSA represented at the ALJ hearing. In the 1980s, SSA tested, and abandoned, a pilot project to have the agency represented - the Government Representation Project (GRP). First proposed by SSA in 1980, the plan encountered a hostile reception at public hearings and from Members of Congress and was withdrawn. The plan was revived in 1982 with no public hearings and was instituted as a one-year “experiment” at five hearing sites. The one-year experiment was terminated more than four years later following congressional criticism and judicial intervention.⁵

Based on the stated goals of the experiment, i.e., assisting in better decision-making and reducing delays, it was a failure. Congress found that: (1) processing times were lengthened; (2) the quality of decision-making did not improve; (3) cases were not better prepared; and (4) the government representatives generally acted in adversarial roles. In the end, the GRP experiment did nothing to enhance the integrity of the administrative process.

The GRP caused extensive delays in a system that was overburdened, even then, and injected an inappropriate level of formality, technicality, and adversarial process into a system meant to be informal and non-adversarial.

The longstanding view of the courts, Congress, and the agency is that the Social Security claims process is informal and non-adversarial, with SSA’s underlying role to be one of determining disability and paying benefits. Proponents of representing the agency believe that SSA is not being fairly represented in the determination process. It is important to note that SSA and the claimant are not parties on opposite sides of a legal dispute. SSA already plays a considerable role in setting the criteria and procedures for determining disability by establishing regulations, Rulings, and other policy guidance; by providing more detailed internal guidance for SSA and DDS workers; and by hiring ALJs. To establish disability, the claimant must follow the rules set by SSA.

In the current non-adversarial process, SSA’s role is not to oppose the claimant. SSA’s role is to ensure that claimants are correctly found eligible if the statutory definition of disability, as contemplated by Congress, is met, whether or not a representative is involved. ALJs, like all adjudicators, have a duty to develop the evidence and investigate the facts. Nevertheless, they should view the claimant’s representative as an ally in collecting necessary and relevant evidence and focusing the issues to be addressed.

⁵ In *Sallings v. Bowen*, 641 F. Supp. 1046 (W.D.Va. 1986), the federal district court held that the Project was unconstitutional and violated the Social Security Act. In July 1986, it issued an injunction prohibiting SSA from holding further proceedings under the Project.

In addition to radically changing the nature of the process, the financial costs of representing the agency at the hearing level would be very high. In 1986, SSA testified in Congress that the cost was \$1 million per year for only five hearings offices in the Project (there currently are more than 140 offices). Also, given that the hearings would be adversarial, SSA would be subject to paying attorneys fees under the Equal Access to Justice Act in appropriate cases.

Given the past experience with government representation and the enormous cost, we believe that the limited dollars available to SSA could be put to better use by assuring adequate staffing at field offices, at the DDSs, and at hearings offices, and developing better procedures to obtain evidence, including reasonable payment for medical records and examinations.

Again, we stand ready to provide additional information or assist in other ways. Thank you for this opportunity to provide additional information.

Sincerely,

Marty Ford
Co-Chair, Social Security Task Force

**Reducing the Disability Backlog at the Social Security Administration and FY 2009
Budget Overview
Questions for the Record**

Answers to Questions by Ronald Bernoski:

1. Question: Your testimony refers to a number of management decisions that have hampered the work of ALJs. Overall, do you believe hearing offices are well-managed? I believe that you heard the Commissioner state that you are opposed to ALJs supervising their own staff. What are your concerns with this approach?

Answer:

With the advent of the Agency's Hearing Office Improvement plan (commonly referred to as HPI) in the late 1990s, the authority and responsibility of most hearing office management staff was substantially eroded. Rather than a Hearing Office Chief Judge with full authority to run the hearing office, including hiring and firing, practically all authority was transferred to the Regional Chief Administrative Law Judges and their respective staffs. Thereafter, in the name of HPI Regional office management staff made critically important personnel decisions as well as operational decisions that adversely impacted the ability of the hearing office to function in an efficient and effective manner. Also, along with HPI came additional hiring in the Regional Offices rather than the hearing offices where backlogs were beginning to develop. Sadly, the Regional offices, with the exception of a few writers, have no positions that are directly responsible for the adjudication of disability claims. To assist in addressing the backlog, we believe that all regional positions should be immediately assigned work directly related to the processing of cases. The American people simply cannot afford the luxury of this unnecessary management layer. We also believe the authority of the Hearing Office Chief Judge position be returned to its pre-HPI status. Presently, the head of the hearing office has no authority to hire, fire or appraise the employees who assist the judges in the adjudicatory process. We are certain that you will find no parallel business model. This current design ensures ineffectiveness and inefficiency.

With respect to the second question, we believe that all ALJ's should have the responsibility and authority to supervise their work at all stages of the adjudicatory pipeline. However, to achieve this desirable result, it is not necessary for the ALJ to have a direct supervisory relationship with support staff. We only need the authority to direct our work including such tasks as returning inadequate draft decisions to staff for revisions. As preponderant as it may sound, we do not presently have that authority. In fact, having a supervisory relationship with staff would substantially increase the amount of non case-related time an ALJ would have to spend on various personnel and administrative tasks. Tasks that would no doubt require additional training and education in personnel law and related regulations. We believe ALJs should spend 100 percent of their time adjudicating cases. Giving ALJs the authority to supervise their work would be the most efficient and effective way to serve the American people.

During the formation of the disability system initiative (DSI) reforms by former Commissioner Barnhart, we met many times with both Commissioner Barnhart and her Deputy Commissioners and we presented a detailed staffing system for the administrative law judge system in the Social Security Administration. In fact, the recent reforms in the Social Security Administration Office of the Chief Judge are based, in part, on our recommendations. Our plans called for the staff to be assigned to the work of the judge. Our suggestions were not adopted and current Commissioner Astrue apparently does not have any interest in continuing this dialogue with our leadership. See Appendix A for the principles of staffing that we presented to the Agency during our discussions.

2. We have heard a lot today about the work of Administrative Law Judges. I would like to ask you to respond to three items in particular:

☐ Question: First, Commissioner Astrue provided information on the plan to reach an optimal level of 1,250 ALJs in FY 2009. Do you agree that this is the appropriate level of ALJs to both reduce the backlog and to process future cases so that the backlog does not re-appear?

Answer:

Increasing the Social Security Corps of ALJs to a level of 1250 judges is clearly a step in the right direction. However, this is only part of the needed correction and the increase of ALJs must be accompanied by a corresponding increase in support staff to assist the judges in performing their work. A judge can not perform his/her work in isolation and the support of sufficient competent and trained staff is essential. We are of the opinion that each judge needs 4 ½ support persons including 2 ½ attorneys and 2 clerical persons. This recommended support staff to judge ratio does not include additional administrative staff and technical support needed to operate each hearing office.

In addition, the system should be changed so that meritorious claims may be granted earlier in the process. Social Security can no longer have over 90% of its disability cases continuing on to a full hearing before an administrative law judge. This systemic change can be accomplished in several ways. One method was attempted by former Commissioner Barnhart. This change was known as the Disability System Initiative plan (DSI). The reform plan attempted to address this problem by eliminating "Reconsideration" at the state DDS level and replacing it with a position known as the "Federal Reviewing Official" (FEDRO). This position was to be filled with an attorney who had the primary responsibility of developing the record for the administrative law judge hearing and awarding benefits "on the record" when appropriate. However, this reform has been abandoned (allegedly because of budgetary considerations) without an adequate "pilot" to test its effectiveness. Another model could be employed which uses a "government representative". This position would be filled by an attorney who has the authority to develop the medical evidence for the record and either settle the case or award benefits when appropriate without a hearing. The government representative could

also appear at the administrative law judge hearing to explain the position of the government in the case. In unrepresented cases, the government representative could advise/assist the claimant in developing his/her case for hearing. A third model could provide for staff attorneys to be assigned to the case dockets of a particular judge. The staff attorney would have the responsibility to develop the medical record in the case for hearing or recommend awarding benefits on the record. Changes such as these are needed, because the Social Security Administration can no longer afford the luxury of trying every case before an administrative law judge. If changes such as these are not made, a Corps of 1250 ALJs may not be sufficient.

Judges alone are not enough. Additional judges, plus systemic change which addresses handling appropriate claims earlier in the process are needed to reduce the current case backlog and to process cases in the future so the backlogs do not recur.

□ Question: Second, Inspector General O'Carroll discussed his audit that revealed a wide disparity in ALJ caseload levels and recommended that a performance accountability process be established. I would be interested in getting your reaction to a performance standard for ALJs. Assuming that there is consultation with ALJs in establishing appropriate performance standards, is this an approach that you would support? Do you have any recommendations on the level of performance that might be appropriate?

Answer:

The Association of Administrative Law Judges has been working on the issue of performance and professional standards of conduct for judges for many years. Our organization started working on this issue in the late 1970's. In 1978 we urged SSA to adopt a code of judicial conduct together with implementation procedures for Federal administrative law judges. During the mid-1980's the Association recommended a "peer liaison" program to the agency to informally mediate disputes within the Office of Hearings and Appeals (now ODAR). During the past few years we have on several occasions recommended to SSA that it adopt the ABA Model Code of Judicial Conduct for Federal Administrative Law Judges as the standard for judicial conduct within the Agency. SSA has on each occasion refused to engage in meaningful substantive dialogue on adopting this needed reform. In this regard, Canon 3 of the Code of Judicial Conduct provides that "an administrative law judge should dispose promptly of the business before the judge". The commentary to the canon states that "prompt disposition of the judge's business requires a judge to devote adequate time to his or her duties, to be punctual in attending hearings and expeditious in determining matters under submission, and insist that other subordinate officials, litigants and their lawyers cooperate with the judge to that end." The conduct of professionals, including judges, is customarily governed by codes of professional conduct and we believe that the same standard should apply to Federal administrative law judges. A code of professional conduct governs all aspects of judging and includes performance in the standards of professional conduct. In fact, the code carries over to the conduct of the judge in his/her private life.

The Association of Administrative Law Judges (AALJ) endorses the concept of ALJ accountability. Every ALJ must account for his/her work both as to quality and quantity. However, there is a distinction between *accountability* and *performance appraisal* based on a set of standards.

The only measure used by SSA to “evaluate” ALJ performance has been the number of ALJ decisions signed and issued at the end of each reporting period. The quality of the dispositions, that is, the legal sufficiency and correctness, is of little, if any, concern to management.

The notion that there is a connection between current ALJ performance and the backlog does not stand up to scrutiny. No significant dent in the backlog would have occurred even if all ALJs had been able to dispose of the number of cases that the agency proposes be recognized as the norm. ALJ dispositions are at a record high, having increased significantly over the past several years. Every year, in fact, the agency has recognized and applauded the increase in ALJ productivity and last year the administrative law judges in the Social Security Administration disposed of over 550,000 cases. As there is no reasonable nexus between the backlog and ALJ levels of “production,” it is illogical to suggest that a solution to the backlog is ALJ performance standards. In fact, a GAO report in December 2007, entitled *Social Security Disability--Better Planning, Management, and Evaluation Could Help Address Backlogs*, stated that the reasons for the disability case backlog included the increase in applications, losses of key personnel and management weaknesses. The report did not place the blame for the backlog at the feet of the ALJs. At a recent Roundtable on the Social Security Backlog, the Honorable David Walker, then head of the GAO, stated that the problems at Social Security were systemic and that no single group in the agency was responsible for the disability backlog.

What we do know is that there are many factors that affect the number of claims that an ALJ can dispose of, including the thoroughness with which the claim is handled, the quality and quantity of staff support, the complexity of the cases (which vary from locality to locality, depending on, among other things, the percentage of cases paid by the state agency and the availability of medical care in the community), the requirements of the Federal courts in the jurisdiction, and the number of claims that can summarily be dismissed because the claimant moves and loses touch with the agency. Furthermore, ALJs may not be available for the entire work year due to military obligations, illness or other duties. That there is a range in the number of claims disposed of by ALJs should not be a matter of concern or surprise.

The Administrative Procedure Act and existing law (5USC section 4301 (2) (D)) prohibit the formal evaluation of ALJs by the agency which employs them for the very good reason that the evaluation process can be used to control the outcome of decisions. Should SSA, or the United States Office of Personnel Management (OPM) for that matter, be permitted to set a minimum number of dispositions per ALJ, the statutory and

constitutional right of the American public to a full and fair hearing on every claim would be adversely affected.

The Federal administrative law judge program is a government wide program subject to the Administrative Procedure Act which was adopted by the Congress in 1946. It would be legally impermissible to create a performance appraisal program that applies only to SSA ALJs and not all Federal government administrative law judges. OPM is the agency with oversight and regulatory control over the Federal administrative law judge program. We question whether OPM is capable of creating reasonable performance criteria and adopting a system that will effectively and fairly implement such program. Moreover, SSA has a pecuniary interest in decision making by ALJs as benefits are paid from its trust fund and there is a danger that the agency would attempt to influence decision making with its appraisal system. There is an impermissible conflict of interest in authorizing an agency to evaluate ALJs when the judge's performance impacts on an issue in the decision making process in which the agency has a direct interest. Would it not be easy for the agency to attempt to use its appraisal system to place undue influence on the decision making of the judge? In fact, this did happen in the 1980's when the Social Security Administration attempted to force some judges to award benefits in fewer claims under its *Bellmon* review program. This program was challenged in a Federal court action, and the decision of the district court judge shows the danger to which the American people become exposed should agencies lawfully possess this authority. The court stated as follows:

In sum, the Court concludes, that defendants' unremitting focus on allowance rates in the individual ALJ portion of the Bellmon Review Program created an untenable atmosphere of tension and unfairness which violated the spirit of the APA, if no specific provision thereof. Defendants' insensitivity to that degree of decisional independence the APA affords to administrative law judges and the injudicious use of phrases such as "targeting", "goals" and "behavior modification" could have tended to corrupt the ability of administrative law judges to exercise that independence in the vital cases that they decide.
(*Association of Administrative Law Judges v. Heckler*, 594 F. Supp. 1132 (1984))

It is not good policy to return to those ugly years and those policies of undue agency influence and intimidation. The American people deserve better.

How do you measure judicial quality? Is it based on the number of cases heard and decided, the legal sufficiency of the decisions, the thoroughness of the handling of the claims, the types of cases heard, or the percentage of cases remanded? All are factors in evaluating an ALJ's efficiency and effectiveness.

Is the OPM capable of creating reasonable performance criteria and a system that will effectively and fairly implement such program? Federal administrative adjudication is a government wide program subject to the Federal Administrative Procedure Act. It would be legally impermissible to create a performance appraisal program that applies only to SSA ALJs and not all Federal government ALJs. Given these considerations, AALJ

believes that it is highly improbable if not impossible for OPM to successfully accomplish such a project. OPM has not been successful in handling the work load that is already assigned to it; it took ten years for OPM to revise the ALJ applications process. Even if OPM were to undertake this task, given the resources necessary to properly evaluate the ALJ corps, would the ultimate cost justify such a program?

Currently, SSA has the right to file an adverse action proceeding with the Merit Systems Protection Board with regard to disciplining or removing an ALJ for good cause, which includes inadequate performance. There is no need for another, elaborate, time-consuming system to deal with a problem which does not exist.

We also bring to your attention the fact that education plays a vital role in good performance. It is important to note that current OPM rules require bar membership for Federal ALJs and that many local bar associations require continuing legal education training. In this regard, our Association has hosted an annual training conference for the past 17 years to provide continuing legal education credits for our judges. The agency has developed a practice of supporting our education conference with some funding and duty time. However, the Agency is now changing its direction and is backing away from contributing funds to the conference. We are thereby respectfully requesting the Appropriations Committee to include a provision in the Social Security Administration appropriations bill which restores this funding and which provides these needed resources for this training conference, at a minimum level of \$200,000 each year. This funding does not pay for the entire cost of the conference because our judges pay their own travel, hotel and food expenses to attend the conference. The Agency's contribution is used mainly for administrative costs for the conference such as presenter fees and expenses, audio/video expenses and reimbursement to the judges for the conference fee.

□ Question: In addition, I would be interested in your view of the rather significant regional disparity we see in processing times, and the current backload of pending hearings by age. I've seen statistics that show a very high percentage of older cases in the Chicago and Atlanta regions. Can you shed any light on this?

Answer:

As to differences in backlogs and adjudicatory time from Region to Region, there are several factors that have to be given consideration. As the Agency is presently managed, there are ten Regional Offices, each headed by a Chief Regional Administrative Law Judge who is supported by a significant number of management positions. These people are removed from direct adjudicatory responsibilities and are thus the least likely to be in a position to make operational decisions on behalf of any hearing office. Moreover, current headquarters management staff perspective does not appear to discourage dispirit application of Agency policy among the regions. Because poor, non uniform regional management decisions adversely affect case processing, including hearing office moral, delay occurs and backlogs continue to build. The ODAR Regional offices are unlike Regional offices of other regulatory agencies where staffs in those offices actually

process cases and render case decisions. As above noted, ODAR Regional office staffs are, with limited exception, not involved in the adjudication of cases. It may interest you to know that approximately 15 years ago, the Regional offices consisted of a Regional chief judge and one or two support staff.

Another factor which has caused backlogs to develop in some regions are the variances in case receipts and staffing levels in particular offices. Moreover, because of decisions of certain Circuit Courts of Appeal, more complex cases may be filed in some parts of the country. By their very nature, such cases require more adjudicatory time. Managing these regional imbalances, whether staffing related, case related or both, can be addressed most efficiently in the Hearing Office by the Hearing Office staff without interference from Regional Management. After all, the Hearing Office Chief Judge is the one accountable for the success or failure of his/her office. He/she should be given the authority and responsibility to deal with these type of issues.

Finally, we also know that imbalances in case receipts result from poor economic conditions. In this regard, with plant closures in both the textile and furniture manufacturing sectors, case social workers actually visit the plants subject to closure. One of the options they suggest to the laid off employee is to file a disability claim. Thousands of such claims have been filed in Southern cities based on such advice.

3. Question: I have asked other witnesses about reconciling the performance information in the SSA budget that states that 97 percent of the decisions made at the State level by the Disability Determination Services on initial claims are accurate, with the fact that more than 60 percent of cases subsequently appealed are ultimately approved for benefits. From your vantage point why are so many of these cases approved at the hearings level? Can you provide any road map for improvements at the State level based on these reasons?

Answer:

A. We do not know what the 97% accuracy rating for the state DDS stands for or how it is determined. We have attempted to find the answer to this question and we will provide all information that we acquire to the Committee. However, it is clear that this rating is not based on a judicial determination and it is not an evaluation made to a scientific certainty. In fact, many cases are denied by both the state DDS and at the hearings level only to be reversed by either the Appeals Council or the Federal courts.

B. In our opinion, cases are approved at the hearings level that have been denied by the state DDS for the following reasons:

- a. Time has passed and often the illness has progressed producing more symptoms and treatment records.
- b. The claimant is represented almost 80% of the time at the hearings level as opposed to being seldom represented at the state level.

- c. The claim is better developed at the hearings level with more medical and vocational evidence.
- d. The claimant has a face-to-face hearing at the hearings level and the ALJ can see and observe the claimant. The claimant has an opportunity to personally describe his/her impairments and symptoms and fully state their case.
- e. The law has evolved in a manner, together with agency policy, which makes it very difficult to deny a claim.

C. Suggested improvements at the state DDS level include the following:

- a. The state DDS should be required to acquire all existing relevant and material evidence for each claim.
- b. The state DDS should apply the same law and regulations that are used at the hearings level.
- c. Provide ALJs with the authority to remand cases to the state DDS for additional case development.
- d. Change the way state DDS employees are evaluated placing less emphasis on whether the claim is awarded or denied and use other criteria for evaluation.
- e. Increase the amount of fees paid to both medical experts and consultative experts.
- f. Conduct Congressional oversight hearings on how the state DDS decides cases, including a review to determine the reason for the wide variance in the claims awarded among the various state DDS.

4. Question: Could you describe more fully how an adversarial hearing and rules of practice would assist the agency and the ALJ in moving forward more quickly on claimants' claims? Given your years of experience, could you please tell us what important elements would be added by this kind of hearing that is missing from SSA's hearings today?

Answer:

The Association of Administrative Law Judges has long advocated that the Social Security Administration be represented at administrative hearings by the Office of General Counsel with authority to advocate the people's interest and with the authority to compromise, settle, and appeal cases.

The Social Security Advisory Board has called for the government to be represented as well. In their 2001 report, the Advisory Board made the following statement:

[T]he fact that most claimants are now represented by an attorney reinforces the proposition, which has been made several times in the past, that the agency should be represented as well. Unlike a traditional court setting, only one side is now represented at Social Security's ALJ hearings. We think that having an individual present at the hearing to defend the

agency's position would help to clarify the issues and introduce greater consistency and accountability into the adjudicative system. It would also help to carry out an effective cross-examination of the claimant. Many ALJs have told us that they are sometimes reluctant to conduct the kind of cross-examination they believe should be made because, upon appeal, the record may make them appear to have been biased against the claimant. Consideration should also be given to allowing the individual who represents the agency at the hearing to file an appeal of the ALJ decision.

This issue has not escaped academic commentators. Two professors made the following caustic observation in the *Journal of Economic Perspectives* (Volume 20, Number 3—Summer 2006—Pages 71–96):

A second promising step would be for the Social Security Administration to consider attorney representation at Administrative Law Judge hearings, as the independent Social Security Advisory Board (2001) has repeatedly recommended. At present, claimants are typically represented at appeal by legal and medical advocates who have a financial stake in the claimant's success. The Social Security Administration, by contrast, is entirely dependent on the Administrative Law Judge to protect the claimant's and the public's interests simultaneously (U.S. GAO, 1997). Permitting the Social Security Administration to provide a representative or attorney to the hearings would ameliorate this almost comically lopsided setting, in which the Social Security Administration currently loses nearly three-quarters of all appeals.

The overriding purpose of the hearing is "fact-finding." We believe that the model used by SSA to conduct hearings is a relatively poor fact-finding model as compared to the adversarial model. We believe that the center of any change at SSA should, at a minimum, include conversion from the inquisitorial model to the adversarial model. The adversarial system of adjudication is fundamental to our American judicial system. We know of no state or Federal court that uses the inquisitorial model to adjudicate issues. SSA uses a model unheard of throughout our land to find facts in a judicial-type setting.

One of the reasons used to justify the current system is the assertion that SSA hearings are non-adversarial. The fact is that SSA hearings are adversarial. The administrative law judge is the claimant's adversary because one of the judge's duties in this system is to protect the interests of the government. We believe the judge's duty is not performed as well as it would be by legal counsel present at the hearing to carry out this function. Furthermore, since the judge is also expected to function as an impartial judge, the system renders the highly efficient and valuable discretionary authority to negotiate and

compromise cases a nullity because ethical rules prohibit judges from engaging in negotiation with a party.

As a fact-finding system, it is difficult for one person to perform all three functions at one time to a high standard. To function as and to appear as an unbiased fact-finder on the one hand and on the other hand to examine a claimant vigorously and thoroughly, as one would expect a lawyer defending the trust fund to do, are not possible to carry out to a high standard. Since the judge has the duty to protect the government's interest, the absence of legal counsel to represent the government's interest in the hearing does not mean that the hearings are non-adversarial. It simply means that the government is not represented by one whose sole function is to represent the government's interest. The hearing is adversarial because the judge is in fact charged with the responsibility of representing and defending the government's interests.

Another concern for preserving the current system is that claimants somehow perceive this SSA system as fair and friendly, and having the government represented would inject an element of hostility to one getting "one's" rightful benefits. The SSA culture is fond of perpetuating the idea that SSA hearings are somewhat paternalistic and claimant-friendly. One can see this in the constant reference to the claimants as "customers." While this is certainly appropriate at the initial claims level, it is not appropriate at the appeal stage. We believe claimants expect to see the government's interests represented by a lawyer for the government, and not by a judge who at the same time is trying to impartially decide the case. Our society is built on the adversarial model and hardly anyone can live in our world without coming into contact with our adversarial system of justice. We believe not only that claimants would not be shocked to see a lawyer appearing at the hearing to represent the government, but also that they would expect to see a judge and a lawyer representing each side.

The benefit of having a lawyer representing the government's interest with the ability to settle cases should not be minimized. In fact, this benefit may be even greater to the administration of justice than the government's role as an advocate. SSA is generally regarded as conducting a high volume of cases. But high volume compared to what? One look at state courts can quickly dispel the idea that SSA's hearing system is high volume. What makes SSA appear high volume is the fact that the vast majority of cases (roughly 90%) are tried. Nowhere in our judicial system is a judge required to take to hearing such a high percentage of cases compared to the total docket. Contrast the huge percentage of cases tried before administrative law judges with the percent tried in Federal courts. One report cited by the New York Times showed that out of all of the federal civil cases filed in 2002, only 1.8% went to trial!¹ Were the state and federal courts required to actually conduct trials in the same proportion as SSA does with its dockets, those courts would abruptly crash under the weight of trying virtually all of their dockets. Having a lawyer with authority to negotiate and settle cases has the potential to

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<http://query.nytimes.com/gst/fullpage.html?res=9C00E3DF133CF937A25751C1A9659C8B63&sec=&spoon=&pagewanted=print>

drastically reduce the number of cases that are tried and conceivably, in the end, reducing the number of judges and support staff.

We believe the adversarial model would far better serve the claimants' and the public's interests by being a better fact-finding system and by more efficiently disposing of cases through compromise and settlement. With a lawyer representing the government, the government can then decide which cases to defend. Instead of hearing 90% of the cases, far fewer cases would go to hearing because of the ability to settle the case without a hearing.

Another efficiency, which should accrue to having government representation, lies in the shepherding of cases through the appeals process. By identifying those claims that are likely to prevail before the judge and agreeing with the claimant's position to enter a favorable award, that just means one less case that has to be scheduled and tried. The government lawyer can then focus resources on defending those cases which ought to be defended rather than spend time on perfunctory hearings.

We believe the SSA's Office of General Counsel should represent SSA in the hearings and should:

- Be primarily responsible for developing the record subject to the approval of the ALJ
- Have the authority to compromise and settle cases subject to ALJ approval
- Have the authority to appeal all cases to the Appeals Council

5. Question: Judge Bernoski, lastly, what are three significant differences between your plan and the agency's plan for reducing the backlog .

Answer:

In our opinion, three major differences exist between our plan to reduce the disability case backlog and the plan developed by the agency. The major differences are as follows:

a. Systemic problems vs. process issues. The recommendations in our reform plan are based on the combined experience of ALJs acquired over many years of hearing and deciding Social Security disability cases. The Commissioner and the Deputy Commissioner of ODAR have very limited experience with Social Security disability. Our reform plan is based on the premise that the Social Security disability system contains systemic problems that must be addressed before the backlog can be addressed in a meaningful manner. Our plan focuses on the "front end" of the process with the goal to handle cases as early as possible and thereby reducing the number of cases that continue on to an ALJ hearing. The alternative is to hire large numbers of ALJs and provide each claimant with a hearing. This creates a more expensive process and requires claimants to wait longer periods of time for decisions. We also recommend

either creating a new position of Social Security counsel or expanding the existing position of staff attorneys as described hereinabove. We recommend adopting improved rules of practice and procedure for our hearings and taking advantage of the pool of talent provided by the claimant attorneys by tasking them to produce all relevant and material evidence in the case. We recommend abolishing the Appeals Council and having most appeals going directly to the Federal court, adopting "prospective closed periods", supporting the judges on "no-show" dismissal orders, improving decision writing, making greater use of senior judges, and contract hire retired SSA employees to address staffing shortages. We also stress the need for more funding to hire additional ALJs and support staff. We suggest a new program of hiring student interns. Agency proposals such as co-locating hearing offices and field offices, using weekly workload reporting, conducting time allocation studies, implementing quality assurance for the hearing process, developing a standardized electronic business process, expanded cooperation between hearing offices, field offices and Area Director Offices, implementing eScheduling, mandating use of the FIT writing template, using video conference hearing equipment, enhancing hearing office management information, implementing centralized printing and mailing, and signing decisions electronically will do little to address the disability case backlog.

b. Long term vs. short term corrections. The agency proposals are short term initiatives and not real corrections to the Social Security disability process. The agency also places an over reliance on technology by proposing corrections such as video conference hearings and electronic files. While we endorse the electronic file, it does not reduce the time it takes a judge to either review the file, conduct the hearing or prepare decision writing instructions. In fact, there is evidence that the use of electronic files may slow down the process at the hearings level.

c. Protecting the due process hearing for claimants. Our proposals are dedicated to preserving and protecting the due process hearing for Social Security claimants that is guaranteed to the American people by the Constitution. We protect the right to this hearing by recommending rules of practice and procedure, improving the due process hearing and ensuring that all of the relevant and material evidence for the claim is made part of the hearing record. On the other hand, the agency proposals remove the claimant from the hearing by using technology for a video conference hearing and the creation of a national hearing center. Both of these proposals remove the claimant from the judge and deny the claimant an in person hearing.

Respectfully submitted,

Ronald G. Bernoski
 Association of Administrative Law Judges
 President

Appendix A

Principles of Staffing for a Hearing Office

1. The HOCALJ reports directly to the Chief Judge.
2. The HOCALJ is appointed by the Chief Judge.
3. The HOCALJ is responsible for the operations and management of the hearing office.
4. The Office Managing Attorney reports directly to the HOCALJ and receives his/her performance rating from the HOCALJ.
5. Support staff and attorney writers shall be assigned to their respective personnel team. Each team shall be responsible for processing the cases assigned to an individual judge's docket. The team's work flow shall be monitored by a senior attorney/attorney who shall report to and be rated by the Office Managing Attorney. Special staff not assigned to a team shall report to the Office Managing Attorney. Management personnel shall assign work to staff personnel as required by workload with primary workload targeted on a particular judge's docket to create efficiency. Judges do not perform any personnel supervision function of any staff person or attorney, although judges may provide supplemental work instructions.
6. The HOCALJ is the senior rater for staff personnel in the hearing office.
7. The HOCALJ shall be permitted to devote up to 75% of their time to administrative duties

Principles of Staffing for the Office of the Chief Judge

1. The Office of the Chief Judge shall be under the management of the Chief Judge.
2. The Chief Judge shall be appointed by the Commissioner.
3. The Chief Judge shall report to the Deputy Commissioner for Disability.
4. The Chief Judge shall submit a budget to the Deputy Commissioner for Disability.
5. The Regional Offices shall be abolished.
6. The Office of the Chief Judge shall consist of several Deputy Chief Judges who are assigned functional responsibilities (e.g. Personnel, Plans and Operations, Finance, Facilities, Systems, Training and LMR, etc.)
7. Deputy Chief Judges shall be appointed by the Chief Judge.
8. Each Deputy Chief Judge will be assigned separate staff/section to develop expertise in their specific functional area of responsibility.
9. The HOCALJs report directly to the Chief Judge.
10. Each HOCALJ shall be supported directly by the Deputy Chief Judge for particular questions or issues on either policy or operation of the hearing office.

Principles Of Staffing

1. Change name of Office of Hearings and Appeals to "Office of Social Security Administration Administrative Law Judges".
2. Administrative law judge to maintain judicial independence as provided by both the Administrative Procedure Act and the Social Security Act.
3. Need to improve the professional status of the ALJ hearing to meet the requirements of the Federal courts.
4. Eliminate position of Associate Commissioner for OHA.
5. Place Office of Social Security Administration Administrative Law Judges under the management of a Chief Judge who reports directly to the Deputy Commissioner for Disability.
6. Abolish OHA Regional Offices
7. Replace RCALJs with additional Deputy Chief Judges assigned to the Office of the Chief Judge with specific areas of responsibility assigned to each Deputy Chief Judge, (e.g. personnel; plans, policy and operations; facilities; and finance)
8. Judges to have authority to return files to RO for further case development.
9. The system must be simple and efficient to serve both the public and the judge.
10. Judges to be assigned to cases from master docket according to law.
11. Judge has responsibility to determine when a decision is legally sufficient and can return it to decision writer for correction as needed.
12. ALJ support staff needs:
 - a. Clerical support. At least one clerical support for each judge to complete work on file, schedule hearings, mail decisions, communicate with claimant and claimant representatives and perform general office clerical work.
 - b. Decision writers. Two attorneys per judge to write ALJ decisions and orders.
13. Staff personnel will be held responsible for the quality and quantity of their work.
14. Hearing office staff
 - a. Office managing attorney
 - b. Attorney writer supervisor
 - c. Staff personnel supervisor*
 - d. Attorney writers
 - e. Clerical workers

- f. Receptionist
- g. Docket clerks*
- h. Technical support*
- i. Administrative support for HOCALJ*
- j. Time/pay clerk

15. HOCALJ is responsible for the operations of the hearing office and the office managing attorney reports to the HOCALJ. HOCALJ is responsible for providing performance appraisal to the hearing office managing attorney.

16. Support staff and attorney writers are members of their respective personnel pools and each member is under the direct supervision of the supervisor of their respective personnel pool. Management cadre will assign work to staff personnel as required by workload with primary workload targeted on a particular judge to create efficiency. Support staff will be assigned to cases and will have very specific duties to meet their responsibilities to their cases. Supplemental work instructions can be provided by the judge. The judge does not perform any personnel supervision function of any staff person or attorney writer.

17. Hearing files to be kept separately for each judge.

18. Comprehensive rules of procedure must be adopted.

19. Assumptions

- a. Social Security disability reforms have been implemented.
- b. Increase the status of the HOCALJ position to improve the quality of the person in the position.
- c. The Reviewing Official (RO) position is implemented.
- d. RO has primary responsibility to develop and assemble exhibits in the hearing case file.
- e. Current "para legal" staff is assigned to the office of the RO as staff.
- f. RO's are located in separate office facilities.
- g. Appeals Council is abolished.
- h. Appeal of administrative law judge decision is directly to the Federal court.
- i. Contract hearing monitors remain.
- j. Assumptions can vary depending on the reform program and its success.
- k. Recommend creating GS-14 Supervisory Attorney position.
- l. Attorney writer position should be classified as GS-9 to 13.

*Number to vary depending on the size of the hearing office

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